EXECUTIVE COUNCIL
COMMITTEE OF THE WHOLE MEETING
May 4, 2021 - 5:30 PM
Room 101

AGENDA

Building, Security & Technology

- Capital Improvement Projects
- Roof Update (Attachment 1)
- Computer Replacement – Leases (Attachment 2)

Program, Policy, and Personnel

- Enrollment 2021-2022
- 2021-2022 Educational Programs and Staffing (Attachment 3)
- Negotiations
- MBIT Health & Safety Plan
    - Modified quarantine
    - Senior Recognition
- Revised Policies (Attachment 4)
    - 903 – Public Participation Executive Council Meetings
    - 006 - Meetings
- Personnel Items
    - COVID Data Coordinator

Finance

- Moody's Credit Rating - Fund balance adjustment
- PSBA Insurance Trust Better Unemployment Compensation Comprehensive (BUCS) program (Attachment 5)
- Flexible Spending Account (FSA) Amendment (Attachment 6)
- Cleaning Services RFP
- Joint Purchasing Arrangement and Cooperatives (Attachment 7)
- Updates (Attachment 8)
    - Li'l Bucks
    - Adult Education

BARRY ISETT & associates INC
MULTI-DISCIPLINE ENGINEERS AND CONSULTANTS

Roofing Invasive Assessment

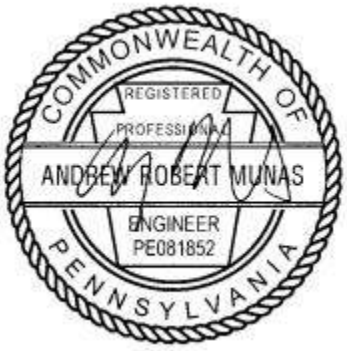
Middle Bucks Institute of Technology
2740 York Road
Jamison, Bucks County, PA 18929

PREPARED FOR:

Mr. Richard Hansen
Facility Manager
Middle Bucks Institute of Technology
2740 York Road
Jamison, PA 18929

Date: April 21, 2021
Project #: 01011421.000

Andy Munas, P.E., HCI-R/C
PA Registration #PE081852
Senior Forensic Engineer
Forensic Engineering Department



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1170 Highway 315, Suite 3, Wilkes-Barre, PA 18702 | 570.285.8200 | 570.285.8201
525 Main Street, Suite 200, Stroudsburg, PA 18360 | 272.200.2050 | 272.200.2051
196 W. Ashland Street, Doylestown, PA 18901 | 267.454.2260 | 267.454.2264
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TABLE OF CONTENTS

INTRODUCTION

On March 9, 2021, Barry Isett & Associates, Inc. performed a site visit at Middle Bucks Institute of Technology (MBIT) at 2740 York Road, Warwick Township, Bucks County, Pennsylvania 18929. Mr. Andy Munas, P.E., HCI-R/C from our office performed the visit. The purpose of the visit was to assess reported insulation movement below a recently installed single-ply roof membrane and to identify locations for invasive investigation. On March 10, 2021, Mr. Munas performed an additional site visit to observe elements exposed by invasive investigation, performed by Munn Roofing. The purpose of this report is to document the findings, identify the extent and significance of damage, and provide conceptual recommendations for repair based on the information from the invasive assessment.

The findings in this report are based on the conditions readily visible at the time of the site visit. Other than the invasive investigation described, no diagnostics, sampling, and/or testing of the existing building materials was performed.

For the purposes of this report, the east side of the building facing lower parking lot shall be taken as "front." All locations will be indicated from a point standing outside the building facing the front, unless noted otherwise.

BACKGROUND

According to Mr. Richard Hansen, Facility Manager with MBIT, the front area of roofing was replaced in 2018 (see Key Plan). Mr. Hansen indicated the roofing replacement was initiated in the Summer and completed in the Fall of 2018. Mr. Hansen reported that the roofing was designed by Roof Consultant Services, Inc. (RCS) and installed by Paneko Construction, Inc. (Paneko). Mr. Hansen reported that the roofing installed was manufactured and warrantied by Versico Roofing Systems (Versico).

Mr. Hansen stated that there were numerous issues during construction, including leaks when the roofing was left open during demolition and prior to completion. Mr. Hansen reported that leaks led to a lot of interior damage that was part of an insurance claim, with the bulk of the restoration being handled by Mellon Restoration. Mr. Hansen reported that, after a lengthy process to rectify punch-list items, Versico issued the warranty in the Spring of 2019.

Mr. Hansen stated that the MBIT staff did not check on the roofing until later in the Spring of 2020 when he realized that the insulation underneath the single-ply roofing membrane had begun to heave and move, causing buckling. Mr. Hansen stated that Versico performed a follow-up site visit and invasive investigation in response to his request. Mr. Hansen reported that Versico stated that the roofing was performing within the warranty, but required MBIT make repairs to maintain that warranty.

DOCUMENT REVIEW

Isett reviewed available documentation, provided by Mr. Hansen, which included the following:

1. **RCS "Partial Roof Replacement" Design Drawings and Specifications dated September 29, 2017.** The drawings state that the roof work was designed to comply with the International Building Code 2009 (IBC 2009). The drawings indicated that the roofing at a front area of the building was to be recovered (see Key Plan). The roofing was to consist of a new 1.5-inch polyisocyanurate (polyiso) insulation (mechanically attached) and a new .060 minimum thickness reinforced EPDM single-ply roof membrane (mechanically attached). The total plan area of the roofing was indicated to be 30,698 square feet. The following was noted in the specifications:

    a. The demolition section required "removal and disposal of all loose gravel surfacing by power brooming and power vacuuming".

b. RCS stated in the specification that they performed an infrared roof moisture scan and identified approximately 952 square feet of wet insulation on the right side of the replacement area. This area was to be demolished to the roof deck and replaced with polyiso to match the surrounding depth. Isett was not provided the details of this infrared scan or if it was performed in accordance with ASTM C1153 – *Standard Practice for Location of Wet Insulation in Roofing Systems Using Infrared Imaging*.

c. Additional "wet or damaged areas that may be found during the course of this project, shall be removed and infilled with new polyisocyanurate insulation to match the existing roof system". No further clarification was provided for who would perform this work or how wet insulation was to be identified.

d. The insulation was to be a "Closed cell polyisocyanurate foam with coated glass facer".

2. **A letter from Brandon M. Mang, Design Analyst from Versico Roofing Systems, to John Kakonikos from Paneko, dated May 17, 2018.** The letter conveyed two different systems that would be acceptable for a Versico Warranty. One system was if the roof construction consisted of concrete deck. The other system was for a minimum 22-gauge steel deck. Versico stated that "all wet or damaged materials are to be removed and replaced with an acceptable substrate". The membrane was to be a 60-mil reinforced EPDM attached with "HPV" fasteners at 12-inches on-center, with 10-foot-wide strips in the field of the roofing and 6.5-foot-wide strips at the perimeter.

3. **Approximately 30 field reports issued by RCS during construction in July, August, and September of 2018.** The reports highlighted the repetitive occurrences of the following:

a. Water intrusion during instances where the existing roofing was left partially demolished and not closed at the end of a workday.

b. Workmanship issues that left the completed roofing open to water infiltration.

c. Interior water damage throughout the building.

d. Roofing and flashing materials installed over wet substrates.

e. Contractor refusing to visit site during rain events to identify areas of active leaking.

f. The field reports do not indicate areas of wet insulation that was removed in addition to the specified 952-square-foot area, despite the field reports indicating multiple days of consistent water infiltration.

4. **An October 11, 2018, Final Inspection Letter from William D. Sanders, President / CEO of RCS, to Mr. Hansen.** The letter stated that an infrared roof moisture survey was conducted on the newly installed roof. Isett was not provided the details of this infrared scan or if it was performed in accordance with ASTM C1153 – *Standard Practice for Location of Wet Insulation in Roofing Systems Using Infrared Imaging*. The letter stated that the scan detected no areas of wet insulation during this inspection and that they "can conclude that the new roof system is free of any detrimental moisture within". The letter also stated that "the overall condition and appearance of the new roof system is considered poor due to the amount of additional punch out work needing to be completed". The report offered a detailed list of the remaining issues with photos and Key Plan.

5. **Versico Field Inspection #2 (February 22, 2019) and Field Inspection #3 (April 11, 2019).** Isett was not provided Inspection #1. Both inspections were performed by Colin Pettinati, Field Service Representative from Versico. Inspection #2 detailed punch-list items to be rectified by the contractor. Inspection #3 did not provide details of the punch-list items but did state that the repairs were completed, and Versico issued the warranty.

6. **An October 29, 2020, letter from Mr. Evan Rose, Warranty Services Manager for Versico, to Mr. Hansen.** The letter detailed information obtained during four test cuts (invasive locations) completed by Versico. The investigation's purpose was to "determine the cause of the curled insulation (approximately 30,000 SF)." The letter states the following:

    a. The visual assessment stated that Versico did not find signs of water entry through the Versico system; however, the investigation did reveal "moisture held in the system, typically on the bottom side of the Carlisle insulation".

    b. "Moisture caused the paper-faced polyiso to curl, affecting the adhesion between the membrane and the insulation".

    c. "While a definitive source was not able to be identified during Versico's investigation, it was apparent the moisture did not originate from a leak in the warrantied Versico Roofing System. As such, the resulting bowing insulation and any other damage or loss of adhesion as a result of the trapped moisture would not be covered under the warranty".

7. **An email from Mr. Rose to Mr. Hansen, dated December 8, 2020.** The email stated that "High winds are likely to occur this time of the year and Versico recommends making repairs to prevent further damage to the roofing system or building. If repairs are not completed, Versico cannot be held liable for damage to the roof or building as a result of these conditions."

OBSERVATIONS

1. The subject area was covered in a mechanically attached EPDM membrane (see Photo #1). Stamps indicated that the EPDM was .060 inches in thickness (see Photo #2). The new roof area was divided into three sections: left, center, and right (see Key Plan).

2. The left and center sections of roofing exhibited warped and displaced insulation that was soft underfoot (see Photos #3 and #4). The right section of roofing exhibited flat insulation at a section toward the rear (see Photo #13); however, all other areas within the right section exhibited warped and displaced insulation. The flat insulation area was consistent with the 952-square-foot area of roofing that was to have the old roofing and wet insulation removed.

3. The roofing exhibited numerous patches and sealant repairs of different colors (see Photos #5 and #6).

4. The roofing exhibited conditions consistent with long-term ponding (see Photos #7 and #8).

5. Some of the patches exhibited failed conditions (see Photos #9 through #11).

6. Some of the fasteners were protruding above the surface of the insulation, causing deformation in the EPDM membrane (see Photo #12).

7. The metal coping and metal and neoprene expansion joints between the left, center, and right sections of roofing were in good condition (see Photo #13).

8. A small parapet area of roofing was in good condition with no leaking reported by the Owner.

9. Four locations were invasively assessed, via an approximately 2-foot-square cut in the roofing (see Photo #14). The cuts were subsequently restored by Munn Roofing.

10. Invasive Location #1 exhibited the following:

    a. The roof cut was located at an area of warped and displaced insulation.

    b. The roofing consisted of three separate layers of roofing. The makeup (top-to-bottom) consisted of a reinforced EPDM membrane, a 1.5-inch-thick paper-faced polyiso layer, another reinforced EPDM membrane adhered to an unidentified base-sheet, another 1.5-inch-thick paper-faced polyiso layer, and finally the original layer of built-up roofing (see Photo #15).

    c. The top layer of insulation was wet to the touch and exhibited a 94% moisture reading when measured with a General Tools MMD7NP pinless moisture meter (see Photo #16).

    d. The lower layer of insulation was dry to the touch and exhibited 0% moisture reading (see Photo #17).

    e. The built-up roofing had been scraped free of loose gravel (see Photo #18).

    f. The fasteners exposed at this location exhibited rusting plates. The observed corrosion has not resulted in loss of capacity; however, continued corrosion will impact the capacity and compromise the service life of the roofing system.

11. Invasive Location #2 exhibited the following:

    a. The roof cut was located at an area of warped and displaced insulation.

    b. The roofing makeup (top-to-bottom) consisted of a reinforced EPDM membrane, a 1.5-inch-thick paper-faced polyiso layer, and the original layer of built-up roofing.

    c. The cut revealed a Styrofoam strip from the EPDM roll that had been left under the roofing. Moisture was visible immediately under the EPDM (see Photo #19). The top of the insulation was wet to the touch and exhibited a 98% moisture reading (see Photo #20).

    d. The bottom of the insulation exhibited organic growth (see Photo #21).

    e. The built-up roofing included loose gravel (see Photo #21).

    f. The fasteners exposed at this location exhibited rusting plates (see Photo #22). The observed corrosion has not resulted in loss of capacity; however, continued corrosion will impact the capacity and compromise the service life of the roofing system.

12. Invasive Location #3 exhibited the following:

    a. The roof cut was located at an area of flat insulation, surrounded by warped and displaced insulation.

    b. The roofing makeup (top-to-bottom) consisted of a reinforced EPDM membrane, a 1.5-inch-thick paper-faced polyiso layer, and the original layer of built-up roofing.

c. The top of the insulation was dry to the touch and exhibited a 0% moisture reading (see Photo #23).

d. The built-up roofing included loose gravel (see Photo #24).

13. Invasive Location #4 exhibited the following:

a. The roof cut was located at an area of flat insulation that corresponded with the "approximately 952-square-foot area" shown on the drawings as wet insulation that was to be replaced down to the steel roof deck.

b. The roofing makeup (top-to-bottom) consisted of a reinforced EPDM membrane, a 1.5-inch-thick paper-faced polyiso layer, a 5-inch-thick paper-faced polyiso layer, and the steel roof deck (see Photo #25).

c. The steel roof deck was in fair condition with surface corrosion observed.

d. The top of the insulation was dry to the touch and exhibited a 0% moisture reading (see Photo #26).

EVALUATION

The observation and documents provided to Isett included the following regarding the design, specification, and inspection work completed by RCS:

1. Approximately 952 square feet of wet insulation had been identified via an infrared moisture scan. This wet insulation was to be replaced down to the metal deck. Isett was not provided details of this infrared roof moisture scan or invasive probes used to confirm the scans. The industry accepted standard with which to perform this infrared roof moisture scan is ASTM C1153 – *Standard Practice for Location of Wet Insulation in Roofing Systems Using Infrared Imaging*. Among other provisions, this standard has requirements for ambient conditions and invasively probing the roofing to verify the lack or presence of moisture identified by the thermal imaging.

2. The specifications called for "wet or damaged areas that may be found during the course of this project, shall be removed and infilled with new polyisocyanurate insulation to match the existing roof system". The field reports do not indicate areas of wet insulation that was removed in addition to the specified 952-square-foot area, despite the field reports indicating multiple days of consistent water infiltration.

3. Details of the RCS infrared roof moisture scan on October 11, 2018, were not provided to Isett; however, the report states that no areas of wet insulation were detected. It could not be determined if this infrared survey followed the provisions of ASTM C1153 for ambient conditions and invasively verifying the lack of moisture that was reported.

The observations and documents provided to Isett included the following regarding the partial roof replacement completed by Paneko:

1. The RCS field reports detailed an extensive history of poor workmanship, active leaks, and roofing being left open at the close of workdays. The amount of leaking documented by these field reports would have resulted in a large portion of the existing roofing insulation being wetted, both under the built-up roofing and newly installed polyiso. The documents provided to Isett do

not identify an effort by Paneko to identify and remove the wet built-up insulation identified in the field reports by RCS.

2. Except for the metal coping and expansion joints, the roof installation was poor. The roofing exhibited multiple failed seams, patches, and areas where roofing exhibited conditions consistent with long-term ponding. It is Isett's opinion, based on observations, that the ponding lasts longer than 48 hours, which exceeds International Existing Building Code (IEBC) requirements. Additionally, the roofing exhibited warping and displacement throughout all areas, except for the area that corresponded with the "approximately 952-square-foot area" shown on the drawings as wet insulation that was to be replaced down to the steel roof deck.

3. Isett's invasive assessment revealed saturated insulation board from infiltrating water and water trapped underneath the recently installed roofing. Some of the moisture present could be from prior to construction activities and from the roofing being left open during construction; however, Invasive Location #1 identified moisture in a top layer of roofing and insulation, while the insulation below the second layer of newly installed roofing remained dry. This indicates that the top layer of roofing leaked after installation, which is consistent with the poor condition of the roofing and multiple open seams and failed patches.

4. Invasive Location #1 identified three layers of roofing: two EPDM layers with polyiso insulation and the original built-up roofing. This is a non-code-compliant installation, as the IEBC and the IBC 2009 requires that all existing layers of roof coverings should be removed down to the roof deck where the existing roof has two or more applications of any type of roof covering.

5. RCS had specified "Closed cell polyisocyanurate foam with coated glass facer". The polyiso observed in the field was paper-faced. Paper-faced polyiso would be less resistant to moisture warping than a coated glass facer version, and this was not identified in RCS field reports as being inconsistent with the construction documents.

6. RCS had specified the "removal and disposal of all loose gravel surfacing by power brooming and power vacuuming". The invasive investigation revealed locations where loose gravel remained under the recently installed insulation board.

The observations and documents provided to Isett included the following regarding the Versico warranty:

1. A May 17, 2018, design letter from Versico states that a mechanically attached EPDM system would be acceptable for warranty. This is consistent with the design documents and the field observations.

2. Versico issued the warranty via Field Inspection #3 on April 11, 2019.

3. Mr. Evan Rose, Warranty Services Manager for Versico, performed test cuts on the subject roofing and detailed the results in a letter dated October 29, 2020. The letter stated the following, which is inconsistent with the installed roofing system:

    a. The assessment identified moisture held in the system, typically on the bottom side of the Carlisle insulation, and that the "moisture caused the paper-faced polyiso to curl, affecting the adhesion between the membrane and the insulation". However, the roofing is a mechanically attached system that does not rely on adhesion between the membrane and the insulation.

b. The assessment stated that, “it was apparent the moisture did not originate from a leak in the warrantied Versico Roofing System”; however, Isett’s field observation and invasive assessment indicates that the recently installed roofing has leaked as a result of the poor condition.

4. Mr. Rose stated in an email on December 8, 2020: “High winds are likely to occur this time of the year and Versico recommends making repairs to prevent further damage to the roofing system or building. If repairs are not completed, Versico cannot be held liable for damage to the roof or building as a result of these conditions.” This statement is also inconsistent with the installed roofing system and may be referencing the assumption that the roofing is an adhered system, as opposed to the mechanically attached system that was installed and warrantied by Versico. The mechanically attached system does not rely on adhesion between the insulation and membrane to resist wind uplift but relies on fasteners installed through the reinforced EPDM at seams.

CONCLUSIONS

Based upon information obtained and relied upon to date, Isett has determined that the newly installed roofing insulation has experienced warping and displacement due to water infiltration and trapped moisture from the following sources:

1. Water leaking through the failed seams and patches observed in the installed roofing. Invasive Location #1 indicates that leaking through the newly installed roofing top layer is a contributor to the moisture in the system.

2. Water that was trapped in the existing built-up roofing insulation before the partial roof replacement commenced and not identified by the infrared scans prior to construction. Many ambient conditions can affect how accurate infrared moisture scans are for detecting hidden moisture and should be verified via invasive probing. It is possible that the infrared moisture scan missed hidden moisture located outside the specified area to be replaced to the steel decking.

3. Water that was introduced via the many documented leaks during construction. RCS identified several times the roofing was left open during the work. RCS also identified active leaking during the work that resulted in damaged interior conditions throughout the building. These conditions would have resulted in the existing insulation (below the built-up roofing) being wetted.

Additionally, the roofing installation is poor and not code-compliant for the following reasons:

1. The open seams and failed patches constitute roofing that is subject to water infiltration.

2. The roofing installation is subject to ponding that lasts longer than 48 hours.

3. At Invasive Location #1, three layers of roofing systems were identified.

RECOMMENDATIONS

Due to the warped and displaced insulation, non-code-compliant and poor roofing installation, and wet insulation, Isett recommends that the entire field of the roof be replaced. Due to the existence of two and sometimes three layers of roofing, code requires all roofing be removed down to the steel deck before a new roofing system is installed. The metal coping and expansion joints were in good

condition; however, if these elements are to be reused, the roofing manufacturer shall approve all details meet their warranty requirements.

Roofing repairs should be designed by a Design Professional licensed in the Commonwealth of Pennsylvania; permitted by the local authority having jurisdiction; and performed in compliance with local code(s) by a qualified contractor with experience in this line of work.

Thank you for the opportunity to perform this assessment. If you have any questions concerning this report, please feel free to contact us.

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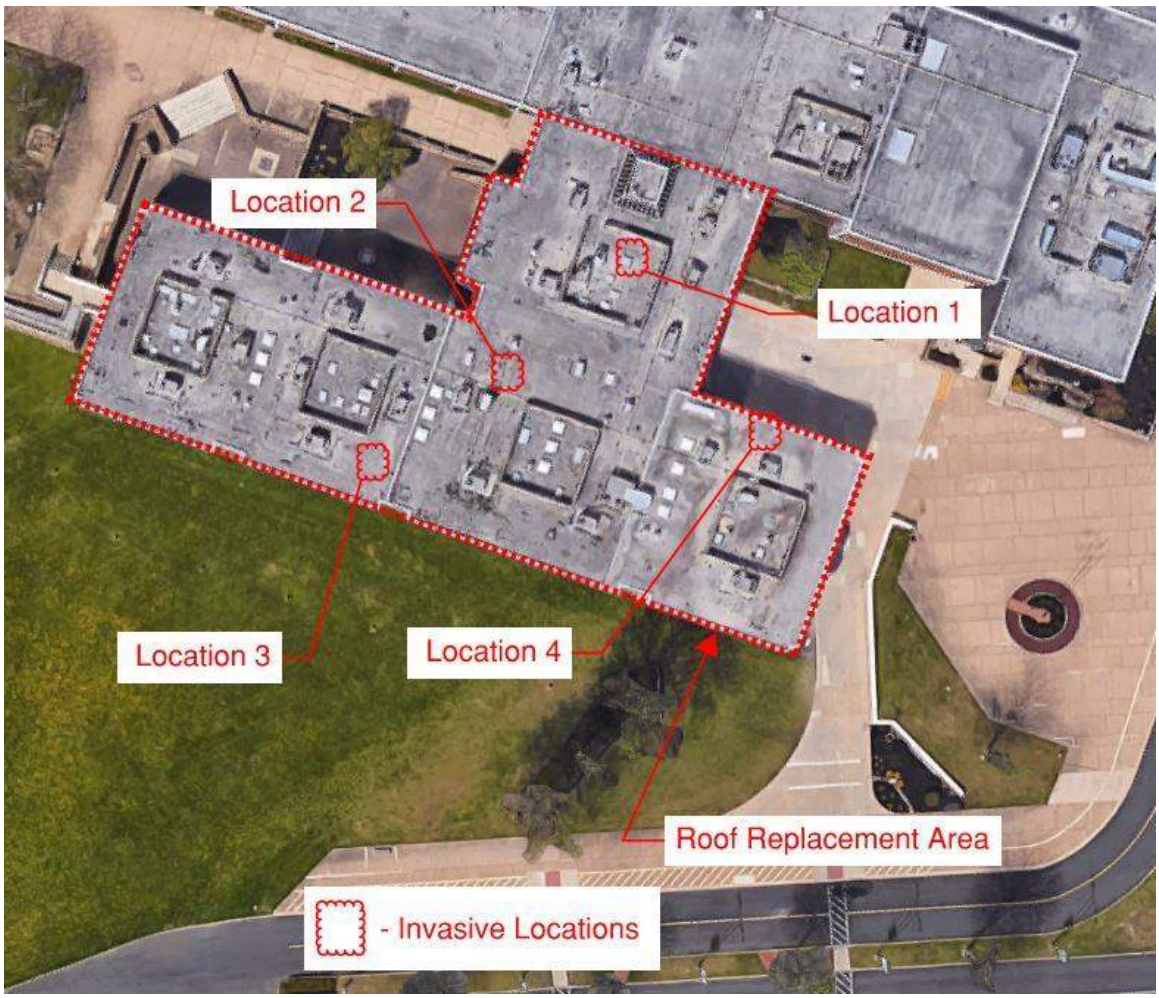
KEY PLAN


Location 2
Location 1
Location 3
Location 4
Roof Replacement Area
- Invasive Locations

PHOTOGRAPHS

(Additional Photographs Available Upon Request)

Photo #1 – EPDM membrane

Photo #2 – Stamp indicating .060 roofing

Photo #3 – Warped and displaced insulation underneath membrane

Photo #4 – Warped and displaced insulation underneath membrane

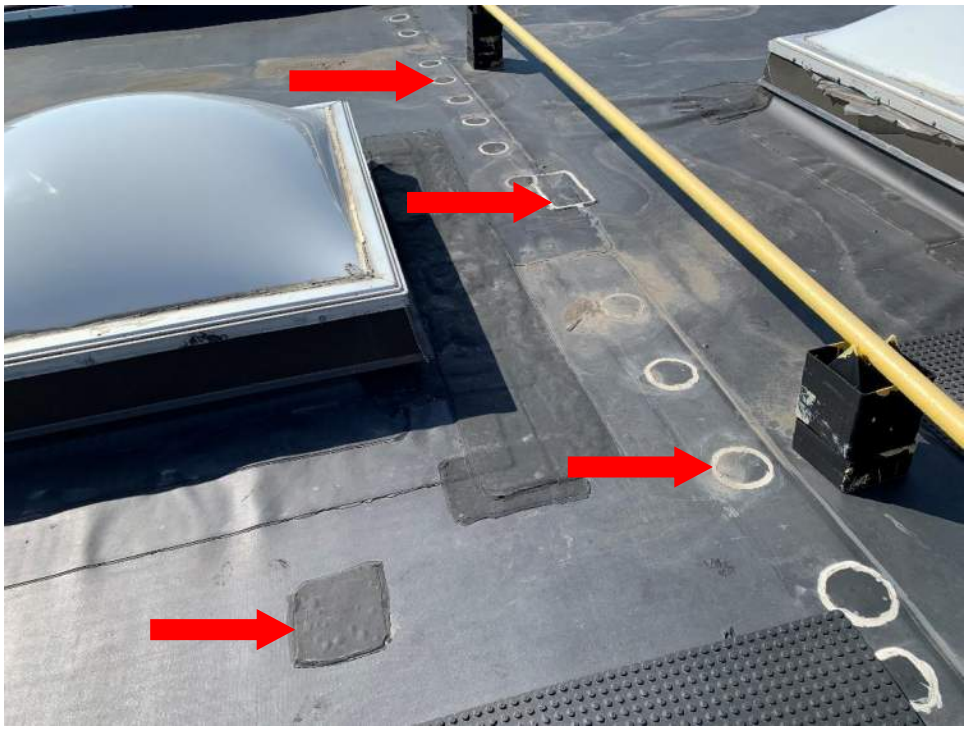


Photo #5 – Multiple different types of patches

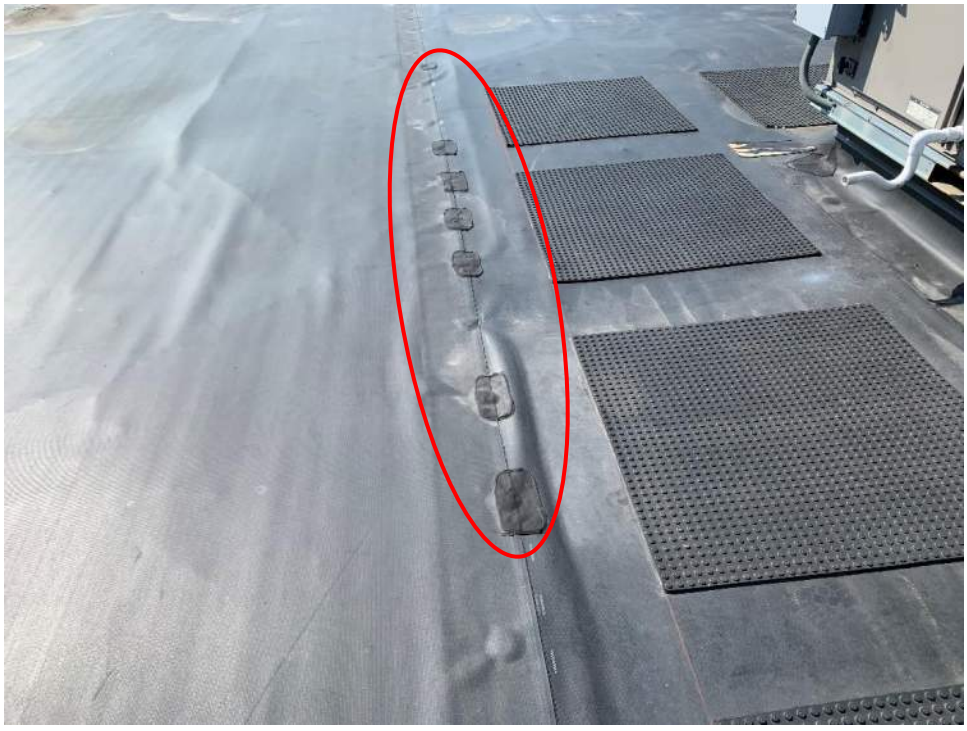


Photo #6 – Patches along seam

Photo #7 – Evidence of long-term ponding

Photo #8 – Evidence of long-term ponding

Photo #9 – Failed patch located in ponding area

Photo #10 – Failed patch located in ponding area

Photo #11 – Failed patch

Photo #12 – Protruding fastener underneath membrane

Photo #13 – Metal coping in good condition and flat insulation toward rear (oval)

Photo #14 – Roof invasive cut

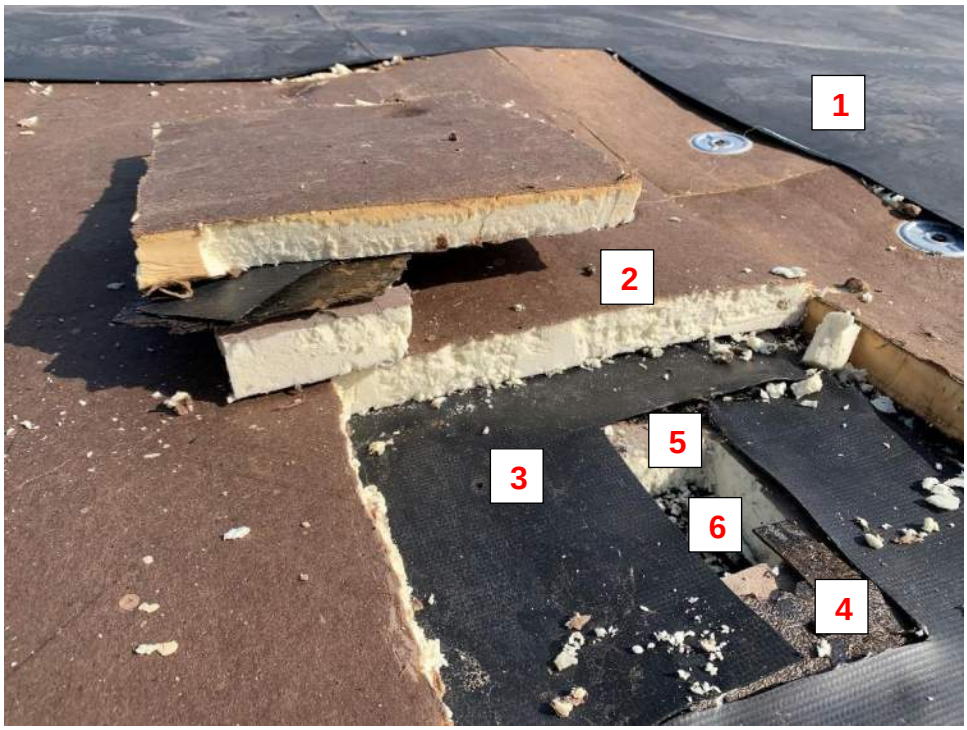


Photo #15 – Invasive Location #1 Layers: 1-EPDM, 2-polyiso, 3-EPDM, 4-base-sheet, 5-polyiso, 6-built-up roofing

Photo #16 – Moisture reading below top layer of roofing at Invasive Location #1

Photo #17 – No moisture detected below middle layer of newly installed roofing at Invasive Location #1

Photo #18 – Built-up roofing with gravel removed

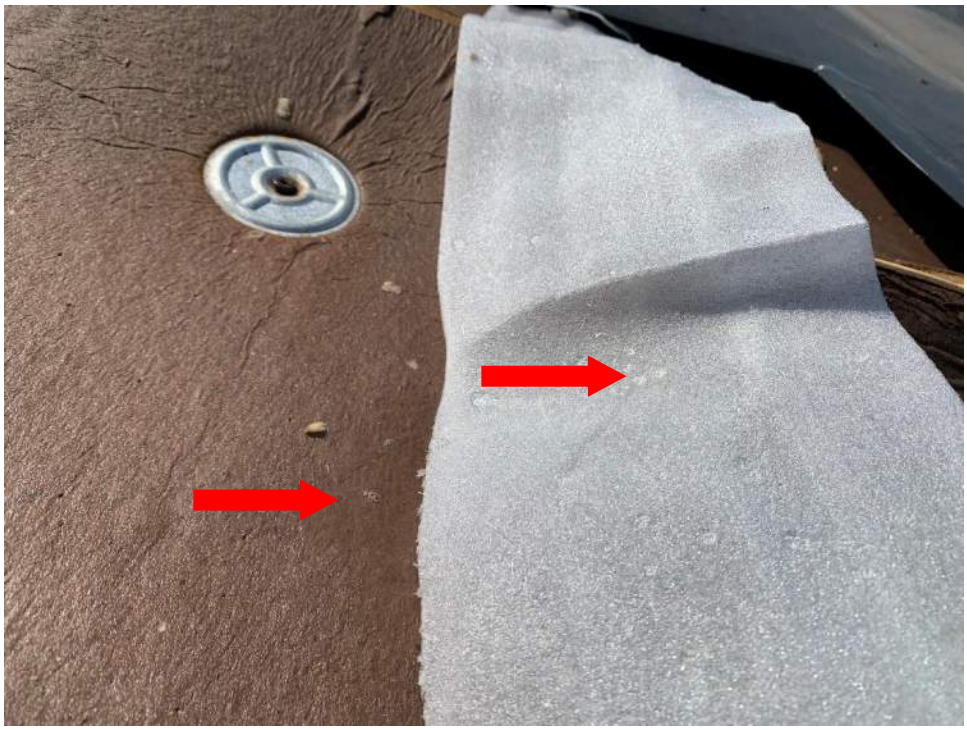


Photo #19 – Moisture underneath EPDM and on Styrofoam strip from the EPDM roll at Invasive Location #2

Photo #20 – Moisture reading below Invasive Location #2

Photo #21 – Organic growth (arrow) and loose gravel at Invasive Location #2

Photo #22 – Rusting plates on fasteners

Photo #23 – No moisture reading at Invasive Location #3

Photo #24 – Loose gravel at Invasive Location #3

Photo #25 – Roofing makeup at Invasive Location #4

Photo #26 – No moisture reading at Invasive Location #4

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April 26, 2021

VIA EMAIL TO *evan.rose@carlisleccm.com*

Evan Rose, Warranty Services Project Manager
Versico Roofing Systems
P.O. Box 1289
Carlisle, PA 17013

RE: Middle Bucks Institute of Technology/Roof

Dear Mr. Rose:

Attached please find a report I received from Middle Bucks Institute of Technology prepared by Barry Isett & Associates, Inc. dated April 21, 2021.

Middle Bucks requests that you provide an answer as to how you intend to remedy this situation with respect to the roof concerns noted in the report. Middle Bucks expects to receive word from you by May 3, 2021, as to what your plans are to rectify the situation.

In the absence of that, you will leave the school with no alternative but to commence litigation.

Very truly yours,

Jeffrey P. Garton

JPG/klk

cc via email: Kathryn Strouse, Administrative Director

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NEW HOPE OFFICE
123 W. BRIDGE STREET
NEW HOPE, PA 18938
215.862.0701

April 26, 2021

Paneko Construction, Inc.
12323 Kemmerton Lane
Bowie, MD 20715

RE: Middle Bucks Institute of Technology/Roof

To Whom it May Concern:

Attached please find a report I received from Middle Bucks Institute of Technology prepared by Barry Isett & Associates, Inc. dated April 21, 2021.

Middle Bucks requests that you provide an answer as to how you intend to remedy this situation with respect to the roof concerns noted in the report. Middle Bucks expects to receive word from you by May 3, 2021, as to what your plans are to rectify the situation.

In the absence of that, you will leave the school with no alternative but to commence litigation.

Very truly yours,

Jeffrey P. Garton

JPG/klk

cc via email: Kathryn Strouse, Administrative Director

MUNN ROOFING CORP.
3413 Unionville Pike Hatfield, PA 19440
P 215-997-2258 F 215-997-1339
www.munnroofingcorp.com

Estimate

ADDRESS
Middle Bucks Institute of Technology
2740 York Rd., Jamison, PA 18929

SHIP TO
Middle Bucks Institute of Technology
2740 York Rd., Jamison, PA 18929

ESTIMATE # 2873
DATE 04/28/2021

JOB LOCATION
Jamison

CONTACT
Rich Hansen

DATE	DESCRIPTION	AMOUNT
04/28/2021	MBIT Phase 2 Roof Overlay (Areas J & M indicated on drawings) Remove all loose gravel and dispose off site Remove wet insulation areas indicated on drawings and replace material in kind Remove capped curbs and infill with steel decking and similar material Remove and dispose existing wall and curb flashings and dispose in asbestos approved dumpster Remove and dispose existing metal flashing and coping metal Furnish and mechanically attach new 1.5” polyiso roof insulation Furnish and mechanically attach new .060 black reinforced single ply roof membrane Furnish and install all new wall flashings, penetration flashings, and terminations Remove and replace existing roof drains Furnish and install new pre-engineered perimeter edge metal Furnish manufacturers 20-year NDL watertight roof system warranty Furnish manufacturers 20-year puncture resistant roof membrane warranty Furnish Munn Roofing Corps 2 year contractor guarantee Exclusions: Overflow Drains This proposal is based off of the drawings and specifications provided 9/9/2020 Munn Roofing is an affiliated member of RoofConnect and utilizes RoofConnect’s Cooperative Contract through OMNIA Partners Contract #: R180902 Certified Proposal Number: PA-R180902-310537 *We have field verified, scaled drawings, and google earthed this project. *It has come to our attention that Roof area M is listed on the drawings at 18,710 SQFT. We believe this number is incorrect. *Our field measurements came to about 13,000 SQFT. Roof areas J & M: $390,800 Roof Areas F,G,H,I,L,K,O,P,N: $998,400	390,800.00

MBIT Phase 2 Roof Overlay (Areas J & M indicated on drawings)	TOTAL	$390,800.00

Accepted By

Accepted Date

Comparison of Computers for 2021-2022

Vendor	**GDC (Dell)**	**VIG (ASUS)**	**IntegraOne (Lenovo)**
Processor	i7 4.8Ghz	i7 4.8 GHZ	i7 4.8GHZ
Ram	16 GB	16 GB	16 GB
DVD/CDR	Yes	Yes	Yes
HardDrive	512 GB SSD	512 GB SSD	512 GB SSD
O.S.	Win 10	Win 10	Win 10
Monitor	20 Inch Flat	20 Inch Flat	20 Inch Flat
Warranty	3 Year	3 Year	3 Year
Cost Per Standard Computer	$1,059.96	$1,041.00	$1,146.47
Total Standard Computer Purchase	$54,057.96	$53,091.00	$58,469.97
Cost Per WEB Computer Purchase	$1,360.68	$1,797.17	$1,170.11
Total WEB Computer Purchase	$35,377.68	$46,726.42	$30,422.86
Imaging of all Computers	$990.00		
Total Computer Purchase	$90,425.64	$99,817.42	$88,892.83
Cost Per iMac	$1,698.00	$1,698.00	$1,698.00
Total cost of iMacs	$37,356.00	$37,356.00	$37,356.00
Total Cost for all computers	$126,791.64	$137,173.42	$126,248.83

Number of Standard Computers-51

Computer Leases

Qty	Vendor	Equipment	
26	GDC	Dell - Precision 3640	$ 35,378
51	GDC	Dell - OptiPlex 3080	$ 54,058
20	Apple	iMac	$ 37,356
			$ 126,791.64

	American Capital Financial Services	First American Equipment Finance	Providence Capital Network	Vantage Financial
Operating Leases				
Equipment Cost	$ 126,792	$ 126,792	$ 126,792	$ 126,792
Term	36 months	36 months	36 months	36 months
Lease Factor	0.07331	0.07632	0.07612	0.07848
Quarterly Rental	$ 9,295.43	$ 9,676.74	$ 9,651.38	$ 9,950.48
End of Term Option	FMV Purchase	FMV Purchase	FMV Purchase	FMV Purchase
Payment Frequency	Quarterly	Quarterly	Quarterly	Quarterly
Interim rents	None	None	None	None
Fees	None	None	UCC	None
Fee$$		$ -	$ -	$ -
Sum of Payments	$ 111,545.16	$ 116,120.86	$ 115,816.56	$ 119,405.77
Interest rate	5.87%	6.11%	6.09%	6.28%
Spread	$ -	$ 4,575.70	$ 4,271.40	$ 7,860.62
Notes			Included paying shipping cost for return at end of lease	Offer $2000 credit for damaged & missing equipment to be returned on schedule 001.

April 30th, 2021

Mr. Robert Vining
Middle Bucks Institute of Technology
2740 York Road
Jamison, PA 18929

Dear Robert:

Thank you for the opportunity to propose lease figures for your upcoming technology acquisition. As you know, American Capital is a leader in providing equipment lease and finance options for Schools and Municipalities.

As members of ASBO, our organization has noted experts in this field who routinely present at ASBO sponsored seminars.

Our expertise in the Education/Municipal Leasing Marketplace is noted by dozens of administrators ranging from Superintendents to Business Managers to Directors of Technology.

The lease options listed below are based upon final credit approval and spread over like term market indexes.

Equipment Cost	Term	Purchase Option	Payment Amount	Lease Rate Factor
$126,791.64	12 Quarters	True Lease (FMV)	$9,295.43/qtr	.07331264

Your absolute satisfaction and positive relationship with American Capital is extremely important to us.

If you have any questions, please ask. Our team looks forward to working further with the Middle Bucks Institute of Technology.

Regards,

Jason Marquardt
Executive Vice President

Service Associate Member of ASBO

Jason Marquardt- Executive Vice President
2015 Ogden Avenue, Suite 400, Lisle, IL 60532
(P) 630-512-0066 x118
jmarquardt@americancapital1.com
www.americancapital1.com

FIRST AMERICAN
AN RBC/CITY NATIONAL COMPANY

LEASE PROPOSAL

Lessor	First American Education Finance 255 Woodcliff Drive, Fairport, NY 14450
Lessee	Middle Bucks Institute Of Technology 2740 Old York Road, Jamison, PA 18929
Equipment	Technology Equipment (98% Hardware)
Equipment Cost	$126,791.64

Lease Options

Lease Term	36 Months
Quarterly Lease Rate Factor	.07632
Quarterly Rental Payment	$9,676.74

Interim Rent	None
Fees	None
FMV Lease	At the end of a FMV Lease you may return individual items of equipment, purchase individual items of equipment, or continue renting individual items of equipment. All returned technology equipment will be handled in a manner that complies with current R2 standards for electronics recycling and data erasure. You will own all software and services for no additional charge.
Rental Payments	The lease will begin on the day you accept the equipment. Rental payments will be due quarterly, in arrears.
Advanced Rental	After you have accepted the equipment and signed the lease, an advance rental in the amount of one month's rent will be due to First American. The advance rental will be applied to the last payment due under the lease.
Rental Rate	Your rental rate is based on the three (3) year swap of 0.47% (referred to as the Index Rate) as of April 26, 2021. Your rate may be adjusted proportionately for any change in the Index Rate prior to funding. It will be fixed for the duration of the lease term.
Master Lease	You have a Master Lease already in place with First American. This new transaction will have minimal paperwork - only equipment schedule specific documents. All terms and conditions will remain consistent with your Master Lease.

You authorize First American to file and record financing statements regarding this transaction and take a first priority security interest in the equipment and deposits. You will be responsible for any purchase orders issued by First American on your behalf. The terms and conditions of this proposal, except for the provisions concerning security interests, will be superseded by the final documentation for each lease schedule. This proposal is not a commitment. First American will only provide lease financing upon the satisfactory completion of its due diligence and mutually acceptable documentation.

First American welcomes the opportunity to continue to serve your financial needs. This proposal expires on May 31, 2021. To accept, please sign below and send an electronic copy to First American.

Offered by:
First American Education Finance

Karen R. Leastman

Karen Leastman, CLFP

Vice President

April 27, 2021

Accepted by:
Middle Bucks Institute Of Technology

By .....

Name.....

Title .....

Date.....

CONFIDENTIAL

Robert Vining
Middle Bucks Institute of Technology
2740 York Road
Jamison, PA 18929

Dear Robert:

Thank you for the opportunity to propose lease figures for your prospective technology acquisition. We have supported hundreds of schools across the country. We are grateful for your previous business and expect the documentation to be the same as before.

The below budgetary lease structure is based upon equipment costs provided by you and the present spread over like term market indexes. The lease is also subject to signed lease documentation, the first payment in July, and credit approval. **There will be no documentation fees, we do not charge Interim Rent and the school will have 30 days of grace period after the term ends in order to return the equipment. Further, we will pay to have the equipment shipped back.**

Structure	Equipment Cost	Term	Buyout	Lease Rate Factor	Payments
Flex Lease	$126,791.64	12 Quarters	FMV	.07612	$9,652

Flex Lease is popular for schools desiring the lowest payments and flexibility to return the equipment at lease end, extend the lease, or purchase the equipment for the Fair Market Value (FMV).

If you'd like to see alternative structures, please ask. Your satisfaction is important to us.

Sincerely,

John Vonder
Providence Capital Network

PROVIDENCE CAPITAL NETWORK
Funding Our Future

SCHOOL BACKGROUND AND TESTIMONIALS

BACKGROUND

Providence Capital has hundreds of school clients nationwide. Schools should not underestimate the importance of working with a partner who excels at supporting leasing and remarketing in this niche market. Here are added reasons to take comfort in our expertise.

- Featured presenter at school seminars
- Member of several school associations
- Contracts embraced by school law firms
- Management experience serving on a school board
- Expertise in remarketing retired computers
- Over 20 years of experience!

CUSTOMIZED FOR YOU

- 1 to 1 program expertise
- Affordable tech refresh leases
- Capital leases for long term ownership
- $10,000 to $5+ million transactions
- Parent/student purchase options
- We buy back end of life equipment
- End of lease rebates!
- Tech, School Buses, Maintenance Equipment & More!

TESTIMONIALS

"Providence Capital provided us with a comprehensive approach to equipment management and financing and our district was able to gain control over the equipment budget. In addition, our out dated equipment was purchased, inventoried and removed with a simple process."

– Business Manager, Illinois Public School District

"Working with Providence Capital made our 1:1 project roll out go very smooth on the financial end. Their experience in working with K-12 made the process go quick and painless. They delivered on what they promised and provided us with top notch service. "

- Technology Director, Indiana School Corporation

"I chose Providence Capital because of their commitment to do whatever it takes to get the financing completed in a timely and cost effective manner. They have never been a "high pressure" firm and I value them as a strong business partner."

– Director of Business Services, Wisconsin Public School District

"From initial quotes to product delivery to subsequent customer care, John made and continues to make our leasing experience tremendous!"

– Superintendent, Wisconsin Public School District

"Thank you for all your help! You certainly helped us by making this process easy."

– Business Manager, Texas Private School

Vantage Financial

Lease Proposal

April 29, 2021

Lessee
Middle Bucks Institute of Technology

Lessor
Vantage Financial

Lease Term
3 years

Equipment to be Leased
$126,791.64 GDC and Apple Quotes

FMV Lease Charge
$9,951/quarterly in arrears

LRF
.078479

Anticipated Delivery
Q2 2021: Once all the Equipment is installed and accepted, the lease will commence at the beginning of the next month.

Fees
Lessor will NOT charge any administration, credit or legal fees. In addition, no interim rent will be charged.

FMV: End of Lease Options
The lessee has the option to return the equipment, purchase of extend the lease.

Value-adds
$2,000 missing and damage credit will apply to returning schedule 001 due back 9/30/21
No damage charges for returns graded A, B or C for this schedule

Contingencies
This proposal and the Lease Agreement are subject to final credit and pricing approval by Lessor. Existing master lease agreement will be used.

Proposal Expiration:
May 31, 2021

We appreciate your consideration of Vantage and look forward to partnering with you on this project. Please do not hesitate to call me should you have any questions regarding this proposal.

Sincerely,
Greg Cousins
203-453-3922
gcousins@vantagefncl.com

**PROPOSED EDUCATIONAL PROGRAMS,
SERVICES AND STAFFING ASSIGNMENTS FOR
2021–2022 SCHOOL YEAR**

PROGRAM	SCHEDULE	INSTRUCTOR
Automotive Technology	A & B	Paul Ciarlone
Automotive Technology	A & B	Robert Schwarz
Building Trades Occupations	A & B	Michael Sykes
Collision Repair Technology	A & B	Ronald Reimel
Commercial Art & Advertising Design	A & B	Bradley Rosenau
Computerized Drafting & Engineering Graphics	A & B	Craig Malinowski
Cosmetology	A & B	Jo Ann McLaughlin
Cosmetology	A & B	Maura Duncan
Culinary Arts & Science	A & B	Kristen Taylor
Culinary Arts & Science	A & B	Michael Stafford
Dental Occupations	A & B	Cynthia Heil
Early Childhood Care & Education	A & B	Lise Rich
Electrical Technology	A & B	Randall McDowell
Engineering Related Technology	A & B	Alan Ostrow
Horticulture, Landscape & Design	A & B	Gregory Smith
HVAC & Plumbing Technology	A & B	Jeffrey Muschlitz
Medical and Health Professions	A & B	Sherry Appleton
Medical and Health Professions	A & B	Lynda Moyer
Multimedia Technology	A & B	James Davey
Networking & Operating Systems Security	A & B	Thomas Omerza
Networking & Operating Systems Security	A & B	Michael Esposito
Public Safety	A & B	John Fala
Residential Construction Carpentry	A & B	Dennis Wicen
School Counselor	A & B	Laurinda Hellwig
School Counselor	A & B	Stephanie Gregory
School Nurse	A & B	Sarah Webber
Special Education Teacher	A & B	Angela Egge
Special Education Teacher	A & B	Sandra Fitzpatrick
Special Education Teacher	A & B	Stacey Flood
Sports Therapy & Exercise Management	A & B	Sean Castineira
Web Design & Interactive Media	A & B	Steven Guinan
Welding Technology	A & B	James Haimovitz
Work-Based Education Teacher/Coordinator	A & B	Thomas Gregor
Work-Based Education Teacher/Coordinator	A & B	Pamela Swoyer

Consider a 3rd Session

ATTACHMENT 4

MIDDLE BUCKS INSTITUTE OF TECHNOLOGY
"Preparing tomorrow's workforce today"

Book	Policy Manual
Section	900 Community
Title	Public Participation Executive Council Meetings
Code	903
Status	
Adopted	July 1, 1991

Purpose

The Executive Council recognizes the value to school governance of public comment on educational issues and the importance of involving members of the public in meetings of the Executive Council.[1]

Authority

In order to permit fair and orderly expression of such comment, the Executive Council will provide a period for public participation at every open meeting of the Executive Council and will formulate rules to govern such public participation in ~~Board~~ Executive Council meetings.

Delegation of Responsibility

The presiding Chairperson~~officer~~ at each public Executive Council meeting will follow the rules for conduct of public meetings in accordance with this policy and Policy 006.

Guidelines

The presiding ~~officer~~Chairperson shall be guided by the following rules:~~[1][2]~~

The Executive Council requires that public participants be residents or taxpayers of the sending school districts or:

1. Anyone having registered a legitimate interest in a contemplated action of the Executive Council.

2. Anyone representing a group in the community or sending school districts.

3. Any representative of a firm eligible to bid on materials or services solicited by the Executive Council.

4. Any school employee.

5. Any school student.

Public participation shall be permitted only as indicated on the order of business in the Procedures of the Executive Council.

All individuals wishing to participate in a public Executive Council meeting shall register their intent in advance of the meeting and shall include the name and address of the participant, topic to be addressed

ATTACHMENT 4

and group affiliation, if applicable.

Participants must be recognized by the presiding Chairpersonofficer and must preface their comments by an announcement of their name and group affiliation, if applicableappropriate.

Smoking is prohibited during meetings of the Executive Council at the Middle Bucks Institute of Technology.

Preregistered speakers must limit their comments to three minutes or less. The presiding Chairperson shall determine when a member of the public has spoken for a reasonable length of time, depending on the item being discussed, before moving on to other speakers or other items of business.

During special public hearings or meetings where many people wish to comment, the presiding Chairperson shall determine the maximum length of time each person may speak.

All statements shall be directed to the presiding Chairperson; no participant may address or question Executive Council members individually.

The presiding Chairperson may:

1. Interrupt or terminate a participant's statement when the statement is too lengthy, personally directed, abusive, obscene, or irrelevant.

2. Request any individual to leave the meeting when that person does not observe reasonable decorum.

3. Request the assistance of law enforcement officers to remove a disorderly person when his/her conduct interferes with the orderly progress of the meeting.

No placards or banners that cause disruption to the meeting will be permitted within the meeting room.

The meeting agenda and all pertinent documents shall be available to the press and public at the meetings

Legal

1. 65 P.S. 271 et seq
2. Pol. 006

ATTACHMENT 4

MBIT
MIDDLE BUCKS
INSTITUTE OF TECHNOLOGY
"Preparing tomorrow's workforce today"

Book	Policy Manual
Section	000 Board Procedures
Title	Meetings
Code	006
Status	First Reading
Adopted	July 1, 1991
Last Revised	November 12, 2018

Parliamentary Authority

"Parliamentary Procedure at a Glance" by O. Garfield Jones shall govern the Executive Council in its deliberations in all cases in which it is not consistent with statute, rules of the State Board, or these procedures.

Quorum

A quorum shall consist of a majority of the voting members of the Executive Council. No business shall be transacted at a meeting without a quorum physically present at the meeting, but the members at such a meeting may adjourn to another time.[2]

Presiding Officer

The Chairperson shall preside at all meetings of the Executive Council. In the absence, disability or disqualification of the Chairperson, the Vice-Chairperson shall act instead; if neither person is present, a member of the Executive Council shall be elected Chairperson pro tempore by a plurality of those present to preside at that meeting only. The act of any person so designated shall be legal and binding.[3][4][5]

Notice

Notice of all open public meetings of the Executive Council, including committee meetings and discussion sessions, shall be given by the publication of the date, place, and time of such meetings in the newspaper of general circulation designated by the Executive Council and the posting of such notice at the offices of the vocational-technical school.

1. Notice of regular meetings shall be given by the publication and posting of a schedule showing the date, place and time of all regular meetings for the calendar year at least three (3) days prior to the time of the first regular meeting.

2. Notice of all special meetings shall be given by publication and posting of notice at least twenty-four (24) hours prior to the time of the meeting, except that such notice shall be waived when a special meeting is called to deal with an actual emergency involving a clear and present danger to life or property.

3. Notice of all rescheduled meetings shall be given by publication and posting of notice at least twenty-four (24) hours prior to the time of the meeting.

4. Notice of all recessed or reconvened meetings shall be given by posting a notice of the place, date and time of meeting and sending copies of such notice to interested parties.

5. Notice of all public meetings shall be given to any newspaper circulating in Bucks County or a radio or television station which so requests. Notice of all public meetings shall be given to any individual who so requests and provides a stamped, addressed envelope for such notification.

Regular Meetings

Regular meetings of the Executive Council shall be public and shall be held monthly at such a time and place as agreed upon.[6]

1. The agenda will be prepared in advance by the Director with the aid and advice of the Executive Council Chairperson.

   Directors may place an item on the agenda by submitting the item in writing to the Director a minimum of ten (10) business days before the Executive Council meeting. In cases when the ten-day notice requirement cannot be met, Executive Council members may verbally submit items to the Chairperson, who will determine the appropriateness of placing the item(s) on the agenda.

   The Director shall distribute agendas to the district Superintendent and Executive Council members on the Thursday prior to a regularly scheduled meeting date.

   Agendas shall be made available to all Executive Council meeting attendees.

2. The order of business shall be as follows, unless altered by the Chairperson or a majority of those present and voting:

   Call To Order
   Pledge of Allegiance
   Roll Call
   Public Comments
   Approval of Minutes
   Administrative Report
   Committee Reports
   Cash Payment Reports
   Treasurer's Report
   Correspondence
   Current Agenda Items
   Adjournment

3. The Executive Council shall take official action on regular business items consistent with the prepared agenda as detailed in this policy (Section 5.a). Additional action items shall be considered only after a motion to add such items to the agenda. Any such motion shall be considered in the nature of a motion "to suspend the rules" and require a two-thirds (2/3) vote of the members present.

Special Meetings

Special meetings shall be public and may be called for special or general purposes.

1. The Chairperson may call a special meeting at any time and shall call a special meeting upon the presentation of requests, in writing, of four (4) members. Upon the Chairperson's failure or refusal to call a special meeting, such meeting may be called at any time by a majority of the Executive Council members.[3]

Hearing of Citizens

A member of the public present at a meeting of the Executive Council may address the Executive Council in accordance with its rules and policy.[7]

Rules of Order

1. The Presiding Office shall require courtesy to prevail at all times.

2. The Presiding Officer cannot offer or second a motion without turning over the gavel. His/Her right is to vote on every question by virtue of membership on the Executive Council.

3. The Presiding Officer may speak to points of order in preference to other Directors and shall decide questions of order. These decisions may be appealed by Executive Council members.

4. If a motion under debate is composed of two (2) or more parts, the Presiding Officer or Executive Council member may request that it be divided. A separate vote must be taken on each part of the divided motion.

5. A motion for adjournment shall always be in order and shall be decided without debate, except that it cannot be entertained when the Executive Council is voting on another question or while a Director is addressing the Executive Council.

6. No Director shall be interrupted while speaking, unless s/he be out of order, or for the purpose of correcting mistakes or misrepresentations.

7. The Presiding Officer shall require debate on any subject pertinent to that subject.

8. Any Director may require a roll call vote on any question.

9. In a roll call vote, order will be at the discretion of the Presiding Officer. An abstention is not considered in determining a majority.

Voting

All motions shall require for adoption a majority vote of those Executive Council members present and voting, except as provided by statute or these procedures.

1. The following actions require a majority vote of the Joint Board, determined by a majority vote of all its voting members and by a concurring vote of three (3) of the four (4) School Boards of the participating school districts:

    a. To purchase a site or sites.

    b. To adopt the annual budget.[8][9]

    c. To approve capital expenditures for buildings.

    d. Or equipment.

2. The following action requires the unanimous consent of all remaining members of the Executive Council: appoint as solicitor of the Executive Council a member who has served for two (2) consecutive terms of four (4) years each, after resigning his/her office.[10]

3. The following actions require the recorded affirmative votes of two-thirds of the full number of Executive Council members:

a. Transfer of budgeted funds.[11]

b. Transfer of any unencumbered balance, or portion thereof, from one appropriation to another, or from one spending agency to another.[8]

c. Elect to a teaching position a person who has served as a school director and who has resigned.[10]

d. Adopt or change textbooks without the recommendation of the Director.[12]

e. Dismiss after hearing of a tenured professional employee.[13]

4. The following actions require the recorded affirmative votes of a majority of the full number of Executive Council members:[14][15]

a. Fixing the length of school term.

b. Adopting textbooks recommended by the Director.

c. Appointing the Director and Principal.[16][17][34][25]

d. Appointing teachers and administrative staff.[19]

e. Selling or condemning land.

f. Locating new buildings or changing the location of old ones.

g. Adopting planned instruction.

h. Establishing additional schools or departments.

i. Designating depositories for school funds.[20]

j. Expending school funds.

k. Entering into contracts of any kind, including contracts for the purchase of fuel or any supplies where the amount involved exceeds $100 (including items subject to $10,000 bid requirements).[21]

l. Fixing salaries or compensation of officers, teachers, or other appointees of the Executive Council.[22][23]

m. Entering into contracts with and making appropriations to other agencies.[14]

n. Dismissing after hearing of a nontenured employee.[14][24][25]

o. Adopting a corporate seal for the school.[26]

p. Vacating and abandoning property to which the Executive Council has title.[27]

q. Determining the holidays, other than those provided by statute, which shall be observed by special exercises and those on which the school shall be closed for the whole day.[28]

r. Removing a member of the Executive Council.[29]

s. Declaring that a vacancy exists on the Executive Council by reason of the failure or neglect of a member to qualify.[29]

t. Removing an officer of the Executive Council.[30]

u. Removing an appointee of the Executive Council.[30]

v. Adopting, amending or repealing a policy or procedure of the Executive Council.[31]

Minutes

The Executive Council shall cause to be made and shall retain a permanent record of the minutes of all open meetings of the Executive Council. Said minutes shall be comprehensible and complete and shall show:[1]

1. The date, place, and time of the meeting.
2. The names of members present.
3. The presiding officer.
4. The substance of all official actions.
5. Actions taken.
6. Recorded votes and a record by individual members of all roll call votes taken.
7. The names of all citizens who appeared officially and the subject of their testimony.

The Secretary shall provide the district Superintendent and each Executive Council member with a copy of the minutes of the last meeting prior to the next regular meeting.

The minutes of Executive Council meetings shall be approved at the next succeeding meeting. The approved minutes shall be signed by the Secretary of the Executive Council.[32]

Notations and any tape or audiovisual recordings shall not be the official record of a public Board meeting but may be available for public access, upon request, in accordance with Board policy. Any notations and/or audiovisual of a Board meeting shall be retained and dispose of in accordance with the school's record retention schedule.

The minutes are not intended to be transcripts of conversations and discussions of items or issues at the meetings. However, a Director may request that a statement or a specific issue be entered verbatim into the minutes. This request must be made at the public meeting at the time of the remarks.

Adjournment

The Executive Council may at any time recess or adjourn to an adjourned meeting at a specified date and place, upon the majority vote of those present. The adjourned meeting shall take up its business at the point in the agenda where the motion to adjourn was acted upon. Notice of the rescheduled meeting shall be given as provided in Pol. 006, Sec. 4,c.[33]

Executive Session

The Executive Council may hold an executive session, which is not an open meeting, before, during, at the conclusion of an open meeting, or at some other time. The presiding officer shall announce the reason for holding the executive session; the announcement can be made at the open meeting prior to or after the executive session.[34][35]

ATTACHMENT 4

The Executive Council may discuss the following matters in executive session:

1. Employment issues.
2. Labor relations.
3. The purchase or lease of real estate.
4. Consultation with an attorney or other professional advisor regarding potential litigation or identifiable complaints which may lead to litigation.
5. Matters which must be conducted in private to protect a lawful privilege or confidentiality.

Official actions based on discussions held in executive session shall be taken at a public meeting.

Discussion Sessions

The Executive Council may meet as a committee of the whole in an open meeting to discuss issues to be acted upon at a subsequent regular or special meeting of the Executive Council, except that no official action may be taken at the discussion meeting. Public notice of such meetings shall be made.

Committee Meetings

Committee meetings may be called at any time by the committee Chairperson with proper public notice.

A majority of the total membership of a committee shall constitute a quorum.[1]

Unless held as an executive session, committee meetings shall be open to the public, other Executive Council members, and the Director.

Each committee chairperson shall appoint a secretary. The committee secretary shall record the minutes and present to the committee the minutes for their approval.

If the committee is not scheduled to meet within the following 4-6 weeks, the minutes are to be mailed with a note that they will be deemed approved as submitted, unless a contrary indication from a member is received.

Once approved, the minutes will be turned over to the Executive Council Secretary and placed on the agenda for approval.

Contents of minutes shall include:

1. Time and place of the meeting.
2. All in attendance, including community and press attendees.
3. All motions and vote results will be recorded.
4. Any committee recommendation to the full Executive Council for consideration must be voted out of the committee by a simple majority.
5. Time of adjournment.
6. Time and place of next meeting.
7. Agenda for the next meeting (subject to updating by the committee chairperson prior to the next meeting).

ATTACHMENT 4

8. Assignments made to committee members or administration.

Legal

2. 24 P.S. 422
3. 24 P.S. 426
4. 24 P.S. 428
5. 24 P.S. 405
6. 24 P.S. 421
7. Pol. 903
8. 24 P.S. 687
10. 24 P.S. 324
11. 24 P.S. 609
12. 24 P.S. 803
13. 24 P.S. 1129
14. 24 P.S. 508
16. 24 P.S. 1071
17. 24 P.S. 1073
19. 24 P.S. 1111
20. 24 P.S. 621
21. Pol. 610
22. 24 P.S. 1075
23. 24 P.S. 1077
24. 24 P.S. 514
25. 24 P.S. 1080
26. 24 P.S. 212
27. 24 P.S. 708
28. 24 P.S. 1503
29. Pol. 004
30. Pol. 005
31. Pol. 003
32. 24 P.S. 433
33. Pol. 006
34. 24 P.S. 1076

PSBA INSURANCE TRUST

Better Unemployment Compensation System (BUCS) Comprehensive Program

Coverage Period July 1, 2021 to June 30, 2022

Program Information

Prepared Exclusively For

Middle Bucks Institute of Technology

Modified Taxable Payroll, from 2020 Bucs Audit Form

78 -	Full time employees at $10,000/ employee	$780,000.00
37 -	Part time employees at gross wages not to exceed $10,000/employee	$63,050.33
	FY 2020/2021 Claim Stop Loss Point	$32,791.51
	FY 2020/2021 Administrative Fee, 15% of Claim Stop Loss Point	$5,656.54

(1) Data from 2020 BUCS Audit Form completed by school entity
(2) Rate calculated using an adjusted commonwealth state rate formula averaging three-year claims and payroll data; the program minimum rate is 2.0%
(3) Administrative Fee covers unemployment claims administrative fees, advisory services and representation, and insurance fees

Should your annual unemployment claims reach your Claims Stop Loss Point, the insurance will cover charges for your school to a limit of three times your Claims Stop Loss Point to a maximum of $750,000.

If you have any questions, contact Kyle Fronk at 717-506-2450 ext. 3380

MIDDLE BUCKS INSTITUTE OF TECHNOLOGY FLEXIBLE SPENDING HIGHLIGHTS

IMPORTANT: ***This is a brief summary of the features of the Middle Bucks Institute of Technology Flexible Spending . For a full summary, please refer to the Summary Plan Description.***

Benefits	
Premium Conversion Account	The Premium Conversion Account can be used to pay the premiums of the following types of coverage: • Employer Group Health • Employer Dental • COBRA continuation coverage under the group health plan
General Purpose Health FSA	Health FSAs may be used to reimburse eligible medical expenses incurred during the year. Employees who are not eligible to participate in the employer health plan are not eligible to participate in the Health FSA.
Dependent Care Account	DCAP Accounts may be used to reimburse eligible dependent care expenses incurred during the year.
Eligibility	
Eligible Employees	Employee will become eligible for the Plan on the first day of the calendar month coincident with or next following the day they meet the following requirements: • Attainment of 21 years of age. The benefits offered under the Plan may have additional eligibility requirements. Please see the SPD for more information.
Excluded Employees	The following Employees are excluded from the Plan: • Part-time employees who are expected to work fewer than 30 hours per week
Enrollment	
Elections	New employees may enroll 30 days after their date of hire. Newly eligible employees who become eligible may enroll within 30 days of the date of eligibility. Ongoing employees may enroll during open enrollment. See SPD when elections may be modified mid-year.
Contributions	
Premium Conversion Account	The amount of the contribution to the Premium Conversion Account is equal to the amount of the Participant's portion of the premium due.
General Purpose Health FSA	The maximum amount the Participant may contribute each year to a General Purpose Health FSA is the maximum amount permitted under the tax code ($2,750 for 2021). The Company will not make additional contributions to the General Purpose Health FSA.
Dependent Care Assistance Plan Account	The maximum amount the Participant may contribute each year to a DCAP Account is the maximum amount permitted under the tax code ($5,000 for 2021 or $2,500 if the Participant is single or married filing separately).
Reimbursement	

General Purpose Health FSA	Timing: The Participant must submit claims for reimbursement from the Participant's General Health FSA no later than 90 days after the end of the Plan Year. Carryover Allowed: up to $500, which may be used to pay or reimburse eligible expenses for the subsequent Plan Year.
Dependent Care Assistance Plan Account	Timing: The Participant must submit claims for reimbursement from the Participant's DCAP Account no later than 90 days after the end of the Plan Year. Any amounts remaining in the Participant's DCAP Account at the end of the Plan Year after all timely claims have been paid will be forfeited.

Contact Information

The Plan Administrator is Middle Bucks Institute of Technology.
Address: 2740 York Road, Jamison, Pennsylvania 18929
Phone number: 215-343-2480

Note: These plan highlights are intended to be a very concise overview of plan features. For a detailed description of plan features, please review the Summary Plan Description or contact the Plan Administrator for more information. The plan features described in these plan highlights are subject to change. In the event of a discrepancy between the legal plan document and these highlights (or any other summary of plan features), the plan document shall control.

MIDDLE BUCKS INSTITUTE OF TECHNOLOGY
FORMAL RECORD OF ACTION

The following is a formal record of action taken by the governing body of Middle Bucks Institute of Technology (the "Company").

With respect to the amendment and restatement of the Middle Bucks Institute of Technology Flexible Spending (the "Plan"), the following resolutions are hereby adopted:

RESOLVED: That the Plan be amended and restated in the form attached hereto, which Plan is hereby adopted and approved;

RESOLVED FURTHER: That the appropriate officers of the Company be, and they hereby are, authorized and directed to execute the Plan on behalf of the Company;

RESOLVED FURTHER: That the officers of the Company be, and they hereby are, authorized and directed to take any and all actions and execute and deliver such documents as they may deem necessary, appropriate or convenient to effect the foregoing resolutions including, without limitation, causing to be prepared and filed such reports, documents or other information as may be required under applicable law.

Dated this _____ day of _____, 2021.

_____

_____

_____

MIDDLE BUCKS INSTITUTE OF TECHNOLOGY
FLEXIBLE SPENDING

TABLE OF CONTENTS

ADOPTION AGREEMENT
CAFETERIA PLAN

The undersigned adopting employer hereby adopts this Plan. The Plan is intended to qualify as a cafeteria plan under Code section 125. The Plan shall consist of this Adoption Agreement, its related Basic Plan Document and any related Appendix and Addendum to the Adoption Agreement. Unless otherwise indicated, all Section references are to Sections in the Basic Plan Document.

COMPANY INFORMATION

1. Name of adopting employer (Plan Sponsor): Middle Bucks Institute of Technology

2. Address: 2740 York Road

3. City: Jamison

4. State: Pennsylvania

5. Zip: 18929

6. Phone number: 215-343-2480

7. Fax number: _____

8. Plan Sponsor EIN: 231701582

9. Plan Sponsor fiscal year end: 06/30

10. Entity Type:

a. Plan Sponsor entity type:

i. **[ ]** C Corporation
ii. **[ ]** S Corporation
iii. **[ ]** Non-Profit Organization
iv. **[ ]** Partnership
v. **[ ]** Limited Liability Company
vi. **[ ]** Limited Liability Partnership
vii. **[ ]** Sole Proprietorship
viii. **[ ]** Union
ix. **[X]** Government Agency
x. **[ ]** Other: _____
xi. If "Union"(10a.viii) is selected, enter name of the representative of the parties who established or maintain the Plan: _____

11. State of organization of Plan Sponsor: Pennsylvania

12. **Controlled Groups/Affiliated Service Groups**

a. **[ ]** The Plan Sponsor is a member of an affiliated service group. List all members of the group (other than the Plan Sponsor): _____

13. **Controlled Groups**

a. **[ ]** The Plan Sponsor is a member of a controlled group. List all members of the group (other than the Plan Sponsor): _____

NOTE: *Affiliated service group members and controlled group members may adopt the Plan with the approval of the Plan Sponsor.*
NOTE: *Listing affiliated service group members and controlled group members is for information purposes only and is optional. Participating Employers in the Plan are listed in Addendum.*

PLAN INFORMATION

A. GENERAL INFORMATION AND DEFINITIONS

1. **Plan Number:** 501

2. **Plan Name:**

a. Middle Bucks Institute of Technology
b. Flexible Spending

3. **Effective Date:** 07/01/2019

a. **[X]** Is this a restatement of a previously-adopted plan?
b. Effective date of Plan restatement: 07/01/2020 ("Restatement Date")

4. **Plan Year:**
a. Plan Years mean each 12-consecutive month period ending on 06/30 (e.g. December 31). If the Plan Year changes, any special provisions regarding a short Plan Year shall be placed in the Addendum to the Adoption Agreement.
b. **[ ]** The Plan has a short Plan Year. The short Plan Year begins _____ and ends on _____.

Plan Features

5. The following Benefits are available under the Plan:
a. **[X]** Premium Conversion Account
b. **[X]** Health Flexible Spending Account
c. **[ ]** Limited Purpose HSA-Compatible Health Flexible Spending Account
d. **[ ]** Post-Deductible HSA-Compatible Health Flexible Spending Account
e. **[X]** Dependent Care Assistance Plan Account
f. **[ ]** Adoption Assistance Flexible Spending Account
g. **[ ]** Health Savings Account
h. **[ ]** Flexible Benefits Credits
i. **[ ]** PTO Purchase/Sale

6. **Simple Cafeteria Plan**
a. **[ ]** The Plan is intended to qualify as a simple cafeteria plan under Code section 125(j).
b. The Employer shall make contributions to the Plan as follows:
i. **[ ]**_____% (no less than 2%) of an Eligible Employee's Compensation for the Plan Year.
ii. **[ ]**_____% (at least 200%) of an Eligible Employee's salary reduction contribution for the Plan Year, but no less than 6% of the Eligible Employee's Compensation for the Plan Year.

B. ELIGIBILITY

Eligible Employees - Employees must meet the following requirements:

1. Minimum age requirement for an Employee to become an Eligible Employee: 21.
NOTE: *If the Plan is intended to be a simple cafeteria plan under Article 12, B.1 may not exceed "21."*

2a. An Employee must complete the following service requirements to become an Eligible Employee on the date set forth in B.2b:
i. **[X]** None
ii. **[ ]** Completion of _____ hours of service.
iii. **[ ]** Completion of _____ days of service.
iv. **[ ]** Completion of _____ months of service.
v. **[ ]** Completion of _____ years of service.
NOTE: *If the Plan is a simple cafeteria plan under Article 12, B.2 may not exceed 1,000 hours of service or one year of service.*

2b. Effective Date of Eligibility. An Employee will become an Eligible Employee on the date below upon completing the age and service requirements in B.1 and B.2a:
i. **[ ]** An Employee shall become an Eligible Employee immediately upon completing the age and service requirements in B.1 and B.2a.
ii. **[X]** first day of each calendar month.
iii. **[ ]** first day of each plan quarter.
iv. **[ ]** first day of the first month and seventh month of the Plan Year.
v. **[ ]** first day of the Plan Year.

2c. If eligibility is not immediate after meeting age and service requirements, an Employee shall become an Eligible Employee on the Eligibility Date in B.1 and B.2b that is:
i. **[X]** coincident with or next following the period in B.2b
ii. **[ ]** following the completion of the period in B.2b.

3. Describe any other modifications to the eligibility rules specified in B.1 and B.2:_____

Excluded Employees

4. The term "Eligible Employee" shall not include:

a. **[ ] Union Employees.** Any Employee who is included in a unit of Employees covered by a collective bargaining agreement, if benefits were the subject of good faith bargaining between employee representatives and the Employer, and if the collective bargaining agreement does not provide for participation in this Plan.

b. **[ ] Leased Employees.**

c. **[ ] Non-Resident Aliens.** Any Employee who is a non-resident alien described in Code section 410(b)(3)(C).

d. **[X] Part-time Employees.** Any Employee who is expected to work fewer than 30 hours per week.

e. **[ ] Other.** _____ (any exclusion must satisfy Code section 125(g) and the requirements under Article 13).

NOTE: *If the Plan is intended to be a simple cafeteria plan, B.4b, B.4d and B.4e may be selected only to the extent that the provisions do not violate the requirements on Code section 125(j).*

5. **[ ]** Describe any modifications to the definition of the term "Eligible Employee" for the specified Plan Benefit: _____

Leave of Absence under FMLA

6. If a Participant takes an unpaid leave of absence under FMLA, the Participant may elect the following with respect to the health Benefits under the Plan (i.e., Premium Conversion Account, Health FSA, and Limited Purpose Health FSA) **(select at least one):**

a. **[X]** Revoke coverage, which will be reinstated under the same terms upon the Participant's return from the FMLA leave of absence.

b. **[X]** Continue coverage but discontinue payment of his or her contribution for the period of the FMLA leave of absence.

7. **[X]** If B.6b. is selected, the Employer may recover the Participant's suspended contributions when the Participant returns to work from the FMLA leave of absence.

8. A Participant on leave of absence under FMLA (select only one):

a. **[X]** may continue coverage for all Benefits for which he is eligible when on FMLA leave, including non-health Benefits.

b. **[ ]** may only continue coverage for Premium Conversion Accounts, Health FSA, and Limited Purpose Health FSA, as applicable.

9. A Participant who continues coverage for Benefits while on FMLA leave of absence may make contributions for such Benefits as follows (select at least one):

a. **[X]** pre-pay on a pre-tax (to the extent permissible under Code section 125) or after-tax basis, prior to commencement of the FMLA leave of absence period, the contributions due for the FMLA leave of absence period

b. **[X]** pay on an after-tax basis the same schedule as payments would have been made if the Participant were not on a leave of absence or if contributions were being made under COBRA

c. **[X]** to the extent agreed in advance, the Participant will repay amounts advanced by the Employer to the Plan on behalf of the Participant upon the Participant's return from the FMLA leave of absence

NOTE: *B.9a may only be elected together with B.9.b or B.9c.*

NOTE: *B.9b must be elected if available for non-FMLA leaves of absence.*

NOTE: *B.9c may only be elected together with B.9a and/or B.9b unless it is the only option available to Participants on a non-FMLA leave of absence.*

Non-FMLA

10. **[X]** A Participant may elect to continue coverage of Benefits when on unpaid non-FMLA leave of absence.

Termination of Participation

11. If a Participant remains an Employee but is no longer an Eligible Employee, his or her participation in the Plan shall terminate:

a. **[X]** on the last day of employment during which the Participant ceases to be an Eligible Employee

b. **[ ]** on the last day of the payroll period during which the Participant ceases to be an Eligible Employee

c. **[ ]** on the last day of the month during which the Participant ceases to be an Eligible Employee

d. **[ ]** on the last day of the Plan Year during which the Participant ceases to be an Eligible Employee

e. **[ ]** Other _____

Reemployment

12. If an Eligible Employee has a Termination of Employment and is subsequently reemployed by the Employer as an Eligible Employee within 30 days after Termination:
- **a. [X]** the Plan Administrator shall automatically reinstate the Benefit elections in effect at the time of Termination
- **b. [ ]** the Eligible Employee shall not resume or become a Participant until the first day of the subsequent Plan Year

13. If an Eligible Employee has a Termination of Employment and is subsequently reemployed by the Employer as an Eligible Employee more than 30 days after Termination:
- **a. [ ]** the Plan Administrator shall automatically reinstate the Benefit elections in effect at the time of Termination
- **b. [ ]** the Eligible Employee shall not resume or become a Participant until the first day of the subsequent Plan Year
- **c. [X]** the Eligible Employee may elect to reinstate the Benefit election in effect at the time of Termination or make a new election under the Plan

C. PARTICIPATION ELECTIONS

Failure to Elect (Default Elections)

1. The election for the immediately preceding Plan Year relating to the following Benefits will apply to the applicable Plan Year:
- **a. [ ]** Premium Conversion Account (Non-Employer-sponsored Contracts)
- **b. [ ]** Health Flexible Spending Account
- **c. [ ]** Limited Purpose/Post-Deductible Health Flexible Spending Account (HSA-Compatible FSAs)
- **d. [ ]** Dependent Care Assistance Plan Account
- **e. [ ]** Health Savings Account
- **f. [ ]** Adoption Assistance Flexible Spending Account

NOTE: *If a Benefit is not selected, an Eligible Employee who does not make an affirmative election under the Plan for a Plan Year will be deemed to have elected not to participate in that Benefit for the Plan Year.*

Change in Status

2. An Eligible Employee may change his or her election upon the following Change in Status events:
- **a. [ ]** None
- **b. [ ]** Any event described in Treas. Reg. section 1.125-4 and other events permitted by IRS guidance
- **c. [ ]** Pursuant to written Plan Administrative Procedures, which are incorporated herein by reference
- **d. [X]** Other: At any time permitted by the IRS regulations and due COVID-19 and CARES Act.

D. PREMIUM CONVERSION ACCOUNT

Contracts for Reimbursement

NOTE: *If Premium Conversion Account is not a selected Benefit under A.5a, Section D is disregarded.*

1. If Premium Conversion Accounts are allowed under the Plan, select the types of Contracts with respect to which a Participant may contribute under Section 5.04:
- **a. [X]** Employer Health
- **b. [X]** Employer Dental
- **c. [ ]** Employer Vision
- **d. [ ]** Employer Short-Term Disability
- **e. [ ]** Employer Long-Term Disability
- **f. [ ]** Employer Group Term Life
- **g. [ ]** Employer Accidental Death & Dismemberment
- **h. [ ]** Individually-Owned Dental

i. **[ ]** Individually-Owned Vision
j. **[ ]** Individually-Owned Disability
k. **[X]** COBRA continuation coverage under the Employer group health plan
l. **[ ]** Other: _____

Enrollment

2. **[ ]** All Employees will automatically be enrolled in the Premium Conversion Account upon their date of hire and will be deemed to have elected to contribute the entire amount of any premiums payable by the Employee during the Plan Year for participation in Employer-sponsored Contract(s).
NOTE: *If D.2 is not selected, Eligible Employees may only elect to participate in the Premium Conversion Account pursuant to Section 4.02(b), 4.02(c) and Section 4.03 of the Plan.*

Contributions

3. **[X]** **Participant elections** will be automatically adjusted for changes in the cost of Employer-sponsored Contracts pursuant to the terms of Treas. Reg. 1.125-4(f)(2)(i).

E. FLEXIBLE SPENDING ACCOUNTS

NOTE: *If Flexible Spending Accounts are not a permitted Benefit under A.5b, Section E is disregarded.*

Employer Contributions

1. **[ ]** **Matching Contributions.** The Plan permits Employer matching contributions to the applicable Benefits as follows:

a. **Health FSA:**
- **i.** **[ ]** None
- **ii.** **[ ]** Discretionary
- **iii.** **[ ]** _____% of the Participant's Health FSA contribution up to _____% of the Participant's Compensation
- **iv.** **[ ]** _____% of the Participant's Health FSA contribution up to $_____
- **v.** **[ ]** Other: _____

b. **Limited Purpose/Post-Deductible Health Flexible Spending Account (HSA-Compatible FSA)**
- **i.** **[ ]** None
- **ii.** **[ ]** Discretionary
- **iii.** **[ ]** _____% of the Participant's HSA-Compatible Health FSA contribution up to _____% of the Participant's Compensation
- **iv.** **[ ]** _____% of the Participant's HSA-Compatible Health FSA contribution up to $_____
- **v.** **[ ]** Other: _____

c. **Dependent Care Assistance Plan Account:**
- **i.** **[ ]** None
- **ii.** **[ ]** Discretionary
- **iii.** **[ ]** _____% of the Participant's DCAP Account contribution up to _____% of the Participant's Compensation
- **iv.** **[ ]** _____% of the Participant's DCAP Account contribution up to $_____
- **v.** **[ ]** Other: _____

d. **Adoption Assistance Flexible Spending Account:**
- **i.** **[ ]** None
- **ii.** **[ ]** Discretionary
- **iii.** **[ ]** _____% of the Participant's Adoption Assistance FSA contribution up to _____% of the Participant's Compensation
- **iv.** **[ ]** _____% of the Participant's Adoption Assistance FSA contribution up to $_____
- **v.** **[ ]** Other: _____

NOTE: *If there are no Employer matching contributions to the Plan, questions under E.1 are disregarded.*
NOTE: *Only one contribution formula is permitted for each applicable Benefit.*

NOTE: *If the Plan is intended to be a simple cafeteria plan, the matching contributions in this section will apply in addition to the contributions at A.6b.*

2. **[ ] Non-Elective Employer Contributions.** The Plan permits Employer contributions to the applicable Benefits as follows:

a. Health Flexible Spending Account:

i. **[ ]** None
ii. **[ ]** Discretionary
iii. **[ ]** _____% of the Participant's Compensation
iv. **[ ]** $_____ per Eligible Employee
v. **[ ]** Other: _____

b. Limited Purpose/Post-Deductible Health Flexible Spending Account (HSA-Compatible FSA):

i. **[ ]** None
ii. **[ ]** Discretionary
iii. **[ ]** _____% of the Participant's Compensation
iv. **[ ]** $_____ per Eligible Employee
v. **[ ]** Other: _____

c. Dependent Care Assistance Plan Account:

i. **[ ]** None
ii. **[ ]** Discretionary
iii. **[ ]** _____% of the Participant's Compensation
iv. **[ ]** $_____ per Eligible Employee
v. **[ ]** Other: _____

d. Adoption Assistance Flexible Spending Account:

i. **[ ]** None
ii. **[ ]** Discretionary
iii. **[ ]** _____% of the Participant's Compensation
iv. **[ ]** $_____ per Eligible Employee
v. **[ ]** Other: _____

NOTE: *If there are no non-elective Employer contributions, questions under E.2 are disregarded.*
NOTE: *Employer matching and non-elective contributions shall not exceed the limits set forth in the BPD including: Health FSA, Section 6.04(b); HSA-Compatible FSA Section 7.04; Dependent Care Assistance Plan Account Section 8.04; and Adoption Assistance Flexible Spending Account, Section 10.04.*
NOTE: *If the Plan is intended to be a simple cafeteria plan, the Employer non-elective contributions in this section will apply in addition to the contributions at A.6b.*

3. **Contribution Limits.** Select the maximum allowable Participant contribution to the applicable FSA in any Plan Year:

a. **[X]** The maximum amount permitted under Code section 125(i), 129(a)(2) and/or 137(b)(1)
b. **[ ]** Other amounts

i. Health Flexible Spending Account: _____
ii. Limited Purpose/Post-Deductible Health Flexible Spending Account (HSA-Compatible FSA): _____
iii. Dependent Care Assistance Plan Account: _____
iv. Adoption Assistance Flexible Spending Account: _____

NOTE: *Other amounts for Health Flexible Spending Account in E.3bi and Limited Purpose/Post-Deductible Health Flexible Spending Account in E.3ii cannot exceed the Code section 125(i) maximum. Other amounts in E.3b.iii for Dependent Care Assistance Plan Account cannot exceed Code 129(a)(2) amounts and E.3b(iv) cannot exceed Code section 137(b)(1) maximum.*

Eligible Expenses

4. **Individual Expenses Eligible for Reimbursement.** Participant may only be reimbursed from the applicable FSA for expenses that are incurred by:

a. **[X] Participant, spouse and Dependents.** The Participant, his or her spouse and all Dependents, and any child (as defined in section 152(f)(1)) of the Participant until his or her 26th birthday:
b. **[ ] Persons covered under Employer-sponsored group health plan.** The Participant, his or her spouse and all Dependents, and any child (as defined in section 152(f)(1)) of the Participant until his or her 26th birthday, but only if such persons are also covered under an Employer-sponsored health plan:
c. **[ ] Participants only.** No reimbursement for expenses incurred by the Participant's spouse or Dependents:

d. **[ ] Other:** _____ (may not include anyone other than the Participant, his or her spouse and all Dependents, and any child (as defined in section 152(f)(1)) of the Participant until his or her 26th birthday)

Expenses Not Eligible for Reimbursement

5. **Expenses Not Eligible for Reimbursement.** In addition to those listed in the Basic Plan Document, the following expenses are not eligible for reimbursement from a Participant's FSA:

a. **[ ]** Health Flexible Spending Account: _____
b. **[ ]** Limited Purpose/Post-Deductible Health Flexible Spending Account (HSA-Compatible FSA): _____
c. **[ ]** Dependent Care Assistance Plan Account: _____
d. **[ ]** Adoption Assistance Flexible Spending Account: _____

6. **Adult Children Coverage.** Reimbursement for adult children may be paid from the applicable FSA for claims incurred:

a. **[X]** until the date the child attains age 26
b. **[ ]** until the last day of the calendar year in which the child attains age 26

Reimbursement

7. **[ ] Amounts Available for Reimbursement.** The Plan Administrator may direct reimbursement of FSAs up to the entire annual amount elected by the Eligible Employee on the Salary Reduction Agreement for the Plan Year for the applicable FSA, less any reimbursements already disbursed from the applicable FSA for the following Benefits:

a. **[ ]** Dependent Care Assistance Plan Account
b. **[ ]** Adoption Assistance Flexible Spending Account

NOTE: *If 7.a or 7.b is not selected, the Plan Administrator may direct reimbursement only up to the amount in the applicable FSA at the time the reimbursement request is received by the Plan Administrator.*

Grace Period

8. **[ ]** The Plan will reimburse claims incurred during a Grace Period immediately following the end of the Plan Year for the following Benefits.

a. **[ ]** Health Flexible Spending Account
b. **[ ]** Limited Purpose/Post-Deductible Health Flexible Spending Account (HSA-Compatible FSA)
c. **[ ]** Dependent Care Assistance Plan Account
d. **[ ]** Adoption Assistance Flexible Spending Account

NOTE: *The Plan cannot reimburse claims incurred during a Grace Period if carryovers are permitted in Part E.12.*

9. **Last day of Grace Period:**

a. **[ ]** Fifteenth day of the 3rd month following end of the Plan Year
b. **[ ]** Other _____

Run Out Period

10. If **no Grace Period** applies for the Plan Year, an active Participant must submit claims for the Plan Year for reimbursement from the applicable FSA no later than:

a. **[X]** 90 days after the end of the Plan Year
b. **[ ]** _____ (insert date, e.g., March 31) immediately following such Plan Year

11. If a **Grace Period** applies for the Plan Year, an active Participant must submit claims for the Plan Year for reimbursement from the applicable FSA no later than:

a. **[ ]** _____ days after the end of the Grace Period
b. **[ ]** _____ (insert date, e.g., March 31st) immediately following such Plan Year

NOTE: *The date in E.11b should be later than the last day of the Grace Period.*

Automatic Payment of Claims

12. Eligible expenses not covered under the Employer-sponsored health plan (e.g., co-payments, co-insurance, deductibles) automatically paid

from the applicable FSA.

a. **[X]** Health Flexible Spending Account

b. **[ ]** Limited Purpose/Post-Deductible Health Flexible Spending Account (HSA-Compatible FSA)

Carryover

13. The Plan will carry over unused Health FSA balances at the end of the Plan Year for the following Benefits:

a. **[X]** Health Flexible Spending Account

i. **[ ]** Maximum amount, as indexed

ii. **[X]** Other: 500

b. **[ ]** Limited Purpose/Post-Deductible Health Flexible Spending Account (HSA-Compatible FSA)

i. **[ ]** Maximum amount, as indexed

ii. **[ ]** Other: _____

NOTE: *If carryover is selected (E.13a or E.13b is selected for the applicable FSA), the Plan may not provide for a Grace Period for the applicable FSA and the Plan may not provide for a Grace Period for the applicable FSA in the Plan Year to which the carryover amount is applied.*

Termination of Employment

14. In the event of a Termination of Employment the Participant may elect to continue to make contributions to FSAs under the Plan on an after-tax basis and reimbursements will be allowed for the remainder of the Plan Year.

a. **[ ]** Yes

b. **[ ]** Yes - subject to the following limitations: _____

c. **[X]** No

NOTE: *If E.14c is selected, then contributions shall cease upon Termination and reimbursements will be allowed only for expenses incurred prior to Termination.*

NOTE: *If applicable, any COBRA elections shall supersede this section.*

15. In the event of a Termination of Employment, a Participant may submit claims for reimbursement from the applicable FSA no later than:

a. **[X]** 90 days after a Termination of Employment.

b. **[ ]** _____ days following the Plan Year in which the Termination occurs.

NOTE: *If E.14a or E.14b is selected, then E.15b must be selected.*

Qualified Reservist Distributions

16. **[ ]** **Qualified Reservist Distributions are available for:**

a. **[ ]** The entire amount elected for the applicable Health FSA for the Plan Year minus applicable Health FSA reimbursements received as of the date of the Qualified Reservist Distribution request.

b. **[ ]** The amount contributed to the applicable Health FSA as of the date of the Qualified Reservist Distribution request minus applicable FSA reimbursements received as of the date of the Qualified Reservist Distribution request.

c. **[ ]** Other amount (not to exceed the entire amount elected for the applicable Plan Year minus reimbursements): _____

F. HEALTH SAVINGS ACCOUNT (HSA Account) (Article 9)

NOTE: *If HSA Account is not a permitted Benefit under A.5g, Section F is disregarded.*

Employer Contributions

1. **Matching Contributions.** The Plan permits Employer matching contributions to the HSA Account as follows (not to exceed the limits in Section 9.04):

a. **[ ]** None

b. **[ ]** Discretionary

c. **[ ]** _____% of the Participant's elected HSA Account contribution up to _____% of the Participant's Compensation

d. **[ ]** _____% of the Participant's elected HSA Account contribution up to $_____

e. **[ ]** Other: _____

NOTE: *If the Plan is intended to be a simple cafeteria plan, the matching contributions in this section will apply in addition to the contributions at A.6b.*

2. **Employer Non-Elective Contributions.** The Plan permits Employer non-elective contributions to the HSA Account as follows (not to exceed the limits in Section 9.04):

a. **[ ]** None
b. **[ ]** Discretionary
c. **[ ]** _____% of the Participant's Compensation
d. **[ ]** $_____ per Eligible Employee
e. **[ ]** Other: _____

NOTE: *If the Plan is intended to be a simple cafeteria plan, the Employer non-elective contributions in this section will apply in addition to the contributions at A.6b.*

3. **Contribution Limits.** Select the maximum allowable contribution to a Participant's HSA Account in any Plan Year:

a. **[ ]** The maximum amount permitted under Code section 223(b), reduced by any Employer contributions.
b. **[ ]** Other amount: _____ (not to exceed the Code section 223(b) maximum when combined with any Employer contributions).

G. FLEXIBLE BENEFIT CREDITS ("Flex Credits") (Section 11.01)

Health Flex Contribution

NOTE: *If Flexible Benefit Credits are not permitted Benefits in A.5h, Section G is disregarded.*

1. **[ ]** **Health Flex Contribution.** The Flex Credit is intended to qualify as a "health flex contribution" under Treas. Reg. section 1.5000A-3(e)(3)(ii)(E): The Participant may not opt to receive the Flex Credit as a cash or taxable benefit and the Participant may only use the Flex Credit for the payment of premiums applicable to health care and toward the Health FSA or HSA-Compatible Health FSA Benefits.

2. **Eligible Benefits.** Participants may elect to contribute the Flex Credits to the following benefits:

a. **[ ]** All Benefits offered under the Plan
b. **[ ]** All Benefits offered under the Plan except the following: _____
c. **[ ]** Only the following Benefits: _____
d. **[ ]** Only the portion of the (i) Premium Conversion Account paid toward Employer-sponsored Health Contract premiums and/or (ii) Health FSA or HSA-Compatible Health FSA Benefits.

NOTE: *If G.1 is selected, G.2d must be selected.*

3. **Amount of Flex Credit.** The Employer will contribute a Flex Credit on behalf of each Eligible Employee as follows:

a. **[ ]** $_____ per Eligible Employee
b. **[ ]** A discretionary amount as determined by the Employer
c. **[ ]** Other: _____
d. **[ ]** The amount of the simple cafeteria plan contributions described in A.6b

4. **[ ]** **Contribution to 401(k) Plan.** An Eligible Employee may elect to contribute all or a portion of his or her Flex Credits to a Qualified Plan in accordance with the terms of the following Qualified Plan(s): _____

NOTE: *If G.4 is selected, then G.5 (cash out) must also be elected.*

Cash Outs

5. **Cash Out of Flex Credits.** A Participant may elect to receive all or a portion of his or Flex Credits in cash.

a. **[ ]** Yes
b. **[ ]** Yes, subject to the following limitations: _____
c. **[ ]** No

NOTE: *If G.5a or G.5b is selected, then Flex Credits a Participant elects to contribute to a Health FSA will count toward the Code section 125(i) contribution limitation.*

NOTE: *If G.1 is selected, G.5c must be selected.*

NOTE: *If G.5.c is selected, the maximum value of Flex Credits a Participant can contribute to a Health FSA for a Plan Year is $500.*

6. **Amount of Cash Out.** For each Flex Credit dollar that a Participant elects to receive in cash from the Plan, the Participant will receive: $_____

(insert dollar value of each Flex Credit; if no amount is provided, the cash out value of each Flex Credit is $1.00)

7. **Maximum Flex Credit Cash Out.** The amount of cash a Participant may receive in exchange for Flex Credits in Plan Year shall not exceed:
   - **a.** **[ ]** No limit
   - **b.** **[ ]** $_____ per calendar year
   - **c.** **[ ]** Other: _____

8. **Payment of Cash Out.** Amounts distributed in cash from the Plan pursuant to Section 11.03 shall be paid to the Participant in:
   - **a.** **[ ]** Equal payroll installments
   - **b.** **[ ]** A single lump sum at the beginning of the Plan Year
   - **c.** **[ ]** A single lump sum at the end of the Plan Year
   - **d.** **[ ]** Other: _____

H. PURCHASE AND SALE OF PAID TIME OFF (PTO) (Section 11.02)

Purchase of PTO

1. **Maximum PTO Purchase.** A Participant can elect to purchase no more than the following periods of PTO in a Plan Year:
   - **a.** **[ ]** None
   - **b.** **[ ]** _____ hours
   - **c.** **[ ]** _____ days
   - **d.** **[ ]** _____ weeks
   - **e.** **[ ]** Other: _____

   NOTE: *If Purchase of PTO is not a permitted Benefit in A.5i, H.1 is disregarded.*

Sale of PTO

2. **Maximum PTO Sale.** A Participant can elect to sell no more than the following periods of PTO in a Plan Year:
   - **a.** **[ ]** None
   - **b.** **[ ]** _____ hours
   - **c.** **[ ]** _____ days
   - **d.** **[ ]** _____ weeks
   - **e.** **[ ]** Other: _____

   NOTE: *If Sale of PTO is not a permitted Benefit in A.5i, H.2 is disregarded.*

Carryover of PTO

3. **[ ] No Carryover of Elective PTO.** Unused elective PTO (determined as of the last day of the Plan Year) shall be paid in cash on or prior to the last day of the Plan Year.

   NOTE: *If Sale and/or Purchase of PTO are not permitted Benefits in A.5i, H.3 is disregarded.*

   NOTE: *If H.3 is not selected, unused elective PTO will be forfeited as of the last day of the Plan Year.*

I. MISCELLANEOUS

Plan Administrator Information

1. **Plan Administrator.**
   - **a.** **[X]** Plan Sponsor
   - **b.** **[ ]** Committee appointed by Plan Sponsor
   - **c.** **[ ]** Other: _____

2. **Indemnification.** Type of indemnification for the Plan Administrator:
   - **a.** **[ ]** None - the Company will not indemnify the Plan Administrator.
   - **b.** **[X]** Standard as provided in Section 14.02.

c. **[ ]** Custom. (If I.2.c. (Custom) is selected, indemnification for the Plan Administrator is provided pursuant to an Addendum to the Adoption Agreement.)

3. **Governing Law.** The following state's law shall govern the terms of the Plan to the extent not pre-empted by Federal law:Pennsylvania

4. **Participating Employers.** Additional participating employers may be specified in an addendum to the Adoption Agreement.

5. **State of Organization.** State of organization of Plan Sponsor:Pennsylvania
(If state law requires written document language regarding benefits herein, add language to Addendum.)

J. EXECUTION PAGE

Failure to properly fill out the Adoption Agreement may result in the failure of the Plan to achieve its intended tax consequences.

The Plan shall consist of this Adoption Agreement, its related Basic Plan Document #125 and any related Appendix and Addendum to the Adoption Agreement.

The undersigned agree to be bound by the terms of this Adoption Agreement and Basic Plan Document and acknowledge receipt of same. The Plan Sponsor caused this Plan to be executed this _____ day of _____, 2021.

MIDDLE BUCKS INSTITUTE OF TECHNOLOGY:

Signature:_____

Print Name: _____

Title/Position:_____

MIDDLE BUCKS INSTITUTE OF TECHNOLOGY

FLEXIBLE SPENDING

SUMMARY PLAN DESCRIPTION

2021-04-08

MIDDLE BUCKS INSTITUTE OF TECHNOLOGY
FLEXIBLE SPENDING
SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

INTRODUCTION

Middle Bucks Institute of Technology (the "Company") established the Middle Bucks Institute of Technology Flexible Spending (the "Plan") effective 07/01/2019. This summary describes the Plan as amended and restated effective 07/01/2020. The Plan is a cafeteria plan that provides an eligible employee with the opportunity to choose among benefits offered under the Plan.

This summary supersedes all previous summaries of the Plan. Although the purpose of this document is to summarize the more significant provisions of the Plan, it is only a summary - the terms of the Plan document ultimately govern the operation and administration of the Plan. The Company and any employer who has adopted the Plan is referred to in this document as the "Company".

ELIGIBILITY

You are an "Eligible Employee" if you are an employee of the Company or any affiliate who has adopted the Plan on the first day of the calendar month coincident with or next following the date you have attained at least 21 years of age.

However, you are not an "Eligible Employee" if you are any of the following:

- A self-employed individual (including a partner), or a person who owns (or is deemed to own) more than 2 percent of the outstanding stock of an S corporation.
- A part-time employee who is expected to work fewer than 30 hours per week.

If you are eligible to participate in the Company-sponsored group health plan, then you are eligible to participate in the Health Flexible Spending Account, even if you do not elect to participate in the Company-sponsored group health plan.

ELECTION PROCEDURES

You may elect to participate in the Benefits under the Plan within 30 days after your eligibility date (or a shorter period if established by the Plan Administrator).

If you do not enroll in the Plan upon your initial eligibility, you may enroll during the enrollment period established by the Plan Administrator. Your election will be effective as of the first day of the Plan Year following the enrollment period.

You may also enroll in the Plan upon a change in status event as described below.

To enroll in the Plan, you may need to submit a completed election form to the Plan Administrator on or before the date specified by the Plan Administrator. If, as of the start of a Plan Year, you have not submitted a completed election form by its due date, you will be deemed to have elected not to participate in the Plan for that Plan Year.

An election to participate in the Plan is generally irrevocable for the Plan Year. You may not change your election during a Plan Year unless you experience a change in status. Your change in election must be on account of and correspond with a change in status that affects your eligibility for coverage under the Plan.

You may change your election as follows: At any time permitted by the IRS regulations and due COVID-19 and CARES Act.

BENEFITS

Contributions pertaining to a Benefit will be credited to the applicable account. Your contributions to the Plan are not subject to federal income tax or social security taxes. Please note that while you may enjoy certain tax benefits, there may be some drawbacks to participation in the Plan. For instance, participation in the Plan may lower your social security benefits. You should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

If you are a highly paid employee or an owner of your Company, federal law may impose limits on your behalf to participate in the Plan and/or the

benefits you may receive from the Plan. If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify your election in order to assure compliance with such requirements or limitations.

Premium Conversion Account

If you elect to contribute to a Premium Conversion Account, the Plan will establish a Premium Conversion Account in your name. Your Premium Conversion Account will be credited with amounts withheld from your compensation. The amount of the contribution to your Premium Conversion Account is equal to the amount of your portion of the premium due for the following benefits/contracts:

- Company Health
- Company Dental
- COBRA continuation coverage under the group health plan

In addition, your election for your premiums will be automatically adjusted for any change in the cost of contracts sponsored by the Company as permitted by applicable law.

If you affirmatively elect not to participate in the Premium Conversion Account for a Plan Year, you will not be enrolled unless and until you elect to participate in the Premium Conversion Account as described in the "Election Procedures" above. Contributions to the Premium Conversion Account are not subject to federal income tax or social security taxes.

In the event of a conflict between the terms of this Plan and the terms of the applicable contract, the terms of the contract (or the benefit plan under which it is established) will control.

Health Flexible Spending Account (Health FSA)

The following Health Flexible Spending Account is available under the Plan:

- General Purpose Health FSA

General Purpose Health FSAs may only be used to reimburse for qualifying medical expenses during the Plan Year.

If you are eligible, you may elect to contribute to a Health FSA in accordance with the "Election Procedures" described above.

Health FSA Eligibility

Please be aware that there are some limitations on your eligibility to participate in Health FSAs. If you are an Eligible Employee, you are eligible to contribute to a Health FSA. However, if you are not eligible to participate in the Company-sponsored group health plan, then you are not eligible to participate in a Health FSA.

Health FSA Contributions

Your Health FSA will be credited with your contributions and will be reduced by any payments made on your behalf. The maximum amount you may contribute each year to your General Purpose Health FSA and/or HSA-Compatible Health FSA is the maximum amount permitted under the tax code ($2,750 for 2021). The Company will not make additional contributions to your General Purpose Health FSA on your behalf.

Health FSA Eligible Expenses/Reimbursement

You will be entitled to receive reimbursement from your General Purpose Health FSA for eligible expenses incurred by you, your spouse and dependents, if any. A dependent is generally someone you may claim as a dependent on your federal tax return and also includes a child until their 26th birthday. The Plan Administrator may direct reimbursement only up to the balance in your Health FSA at the time your submit reimbursement request to the Plan Administrator.

You may receive reimbursement for eligible expenses incurred during the Plan Year when you are participating in your Health FSA. Eligible expenses generally include all medical expenses that you may deduct on your federal income tax return. Health insurance premiums are not an eligible expense for the Health FSA.

You will not be reimbursed for any expenses that were (1) incurred before you are eligible to participate in the Health FSA; (2) incurred after you have become ineligible to participate in the Health FSA and are attributable to a tax deduction you took in a prior taxable year; or (3) covered, paid,

or reimbursed from another source. Your claim for reimbursement must include substantiation that the Plan Administrator or Claims Administrator considers sufficient for determining that the claim constitutes an expense eligible for reimbursement under the Plan.

If you are a participant in any Company-sponsored benefit plan, eligible expenses that are not covered under the benefit plan, such as co-payments, co-insurance or deductibles, will be automatically paid through your General Purpose Health FSA.

You must submit claims for reimbursement from your General Purpose Health FSA no later than 90 days after the end of the Plan Year. Any amounts remaining in your Health FSA after all timely claims have been paid will be forfeited.

Notwithstanding the forfeiture provisions above, if you have a balance in your Health FSA as of the last day of the Plan Year after all eligible expenses have been reimbursed and the claims deadline for the Plan Year has passed, the Plan will carry over the balance from your Health FSA, up to $500, which may be used to pay or reimburse eligible expenses for the subsequent Plan Year. Any amounts in your Health FSA that exceed the limit above will be forfeited.

Termination of Employment

If you terminate employment with the Company for any reason during the Plan Year, your contributions to your FSA will end as of your date of termination. You may submit claims for reimbursement from your FSA for expenses incurred during the Plan Year prior to your termination of employment. You must submit claims for reimbursement from your Health FSA no later than 90 days after the date your employment terminates. Any balance remaining in your Health FSA will be forfeited after claims submitted prior to this date have been processed.

Dependent Care Assistance Plan Account (DCAP)

A Dependent Care Assistance Plan Account may be used to reimburse expenses incurred for the care of a qualifying dependent. If you are eligible, you may elect to contribute to a DCAP Account in accordance with the "Election Procedures" described above.

DCAP Contributions

Your DCAP Account will be credited with your contributions and will be reduced by any payments made on your behalf. The maximum amount that you may contribute each year to your DCAP Account is the maximum amount permitted under the tax code ($5,000 for 2021, $2,500 if you are married and filing separately.)

The Company will not make additional contributions to your DCAP Account on your behalf.

DCAP Eligible Expenses/Reimbursement

The amount available for reimbursement is the balance in your DCAP Account at the time the reimbursement request is received by the Plan Administrator or Claims Administrator. You may receive reimbursement for eligible expenses incurred during the Plan Year when you are participating in your DCAP Account. Eligible expenses generally include those that you incur in order to be gainfully employed and for the care of (i) your dependent who is under age 13, or (ii) your spouse or dependent who lives with you and who is physically or mentally incapable of caring for themselves. Expenses incurred for overnight camp are not eligible for reimbursement. A dependent is generally someone who you may claim as a dependent on your federal tax return.

You must submit claims for reimbursement from your DCAP Account no later than 90 days following the Plan Year. Any amounts remaining in your DCAP Account at the end of the Plan Year after all timely claims have been paid will be forfeited.

Termination of Employment

If you terminate employment with the Company for any reason during the Plan Year, your contributions to your DCAP Account will end as of your date of termination. You may submit claims for reimbursement from your DCAP Account for expenses incurred during the Plan Year prior to your termination of employment. You must submit claims for reimbursement from your DCAP Account no later than 90 days after the date your employment terminates. Any balance remaining in your DCAP Account will be forfeited after claims submitted prior to this date have been processed.

CLAIMS PROCEDURES

You must submit your claim for benefits in accordance with the Plan Administrator's guidelines. Claims may also be submitted to CBIZ Payroll at:

Address: 2797 Frontage Rd, Suite 2000
Phone number: 855-410-2249

Any claim for benefits must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merits of the claim. The Plan Administrator may request any additional information necessary to evaluate the claim.

To the extent that the Plan Administrator approves a claim, the Company may either (i) reimburse you, or (ii) pay the service provider directly. The Plan Administrator will pay claims at least once per year. The Plan Administrator may provide that payments/reimbursements of less than a certain amount will be carried forward and aggregated with future claims until the reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments/reimbursements outstanding at the end of the Plan Year will be reimbursed without regard to the minimum payment amount.

Claims for Plan Benefits (except for Health FSAs)

You must file a claim for benefits under this Plan in accordance with the Plan Administrator's guidelines. If your claim does not include enough information to process the claim, you will be given an opportunity to provide the missing information. You may designate an authorized representative by providing written notice of the designation to the Plan Administrator.

You may apply for benefits under the Plan by completing and filing a claim with the Plan Administrator. Your claim must include all information and evidence that the Plan Administrator deems necessary to evaluate the merit of your claim and to make any necessary determinations on your claim. The Plan Administrator may request any additional information from you as necessary to evaluate the claim.

Claims for Health FSA Benefits

If you file a claim for benefits from your Health FSA and that claim is denied, the Plan Administrator will notify you within a reasonable period of time, but no later than 30 days after the Plan Administrator received the claim. The Plan Administrator may notify you, prior to the expiration of this 30-day period, of the need to extend the period by up to 15 days due to matters beyond its control. In such case the Plan Administrator will notify you of the circumstances requiring the extension of time and the date by which the Plan Administrator will notify you of its decision. If the extension is necessary because you did not submit information necessary to decide the claim, the notice of extension will describe the required information, and you will have at least 45 days from the day you receive the notice to provide the specified information.

If your claim is denied, the Plan Administrator will provide you with a notice identifying (A) the reason or reasons for the denial, (B) the Plan provisions on which the denial is based, (C) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (D) an explanation of the steps that you must take if you wish to appeal the denial, including a statement that you may bring a civil action under ERISA after following the Plan's claims procedures. The notice will also include (1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; or (2) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Appeal of Denied Claim. If you wish to appeal the denial of a claim, you must file an appeal with the Plan Administrator on or before the 180th day after you receive the Plan Administrator's notice that the claim has been denied. You will lose the right to appeal if the appeal is not made within this 180-day period. The appeal must identify both the grounds and specific Plan provisions upon which the appeal is based. You will be provided, upon request and free of charge, documents and other information relevant to your claim. Your appeal may also include any comments, statements or documents that you desire to provide. The Plan Administrator will consider the merits of your presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator will:

(A) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the denial that is the subject of the appeal, nor the subordinate of such individual;

(B) Provide that, in deciding an appeal of any denial that is based on a medical judgment, including determinations with regard to whether a

particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(C) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim denial, without regard to whether the advice was relied upon in making the denial; and

(D) Provide that the health care professional engaged for purposes of a consultation under (B) above will be an individual who is neither an individual who was consulted in connection with the denial that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator will notify you of the Plan's benefit determination on review within 60 days after receipt by the Plan of your request for review of the denial.

Denial of Appeal. If your appeal is denied, the Plan Administrator will provide you with a notice identifying (A) the reason or reasons for such denial, (B) the Plan provisions on which the denial is based, (C) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and (D) a statement describing your right to bring an action under section 502(a) of ERISA after following the Plan's claims procedures. The determination rendered by the Plan Administrator shall be binding upon all parties.

Exhaustion of Remedies; Limitations Period for Filing Suit. Before you can file a lawsuit for benefits under the Plan, you must exhaust the Plan's internal remedies. A lawsuit for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

Benefits Provided under Contracts. Please see the underlying contracts for any additional claims and reimbursement rules under those contracts.

Debit/Credit Cards

Middle Bucks Institute of Technology will provide you with a debit/credit and/or other stored-value card for purposes of making purchases that are eligible for reimbursement from your Health Flexible Spending Account and/or Dependent Care Assistance Plan Account. The Plan Administrator will provide you with more information about these cards as well as any limitations at the time you enroll in the Plan. You do not have to use the cards and may request reimbursements as listed above.

COBRA CONTINUATION COVERAGE

If you are participating in the Health FSA and your Company is not a small employer, then COBRA applies. A "small employer" is generally an employer that employs fewer than 20 employees, but you should contact the Plan Administrator who can inform you if the Company is a small employer not subject to COBRA and is not required to comply with these rules. Depending on your Health FSA balance at the time of the Qualifying Event (described below), you may not be eligible for COBRA continuation coverage.

Qualifying Events

You have the right to continue your coverage under the Health FSA if any of the following events results in your loss of coverage under the Health FSA:

- termination of employment for any reason other than gross misconduct
- reduction in your hours of employment

Your spouse and dependent children (including children born to you or placed for adoption with you) have the right to continue coverage under the Health FSA if any of the following events results in their loss of coverage under the Health FSA:

- termination of your employment for any reason other than gross misconduct
- reduction in your hours of employment
- you become enrolled in Medicare
- you and your spouse divorce or are legally separated
- your death
- your dependent ceases to be a "dependent child" for purposes of COBRA

Persons entitled to continue coverage under COBRA are "Qualified Beneficiaries."

If the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available under the Health FSA for the remainder of the Plan Year, you, your spouse, and/or your dependent child(ren) generally do not have the right to elect

COBRA continuation coverage. You will be provided notice which explains your rights regarding COBRA continuation coverage.

Continuing Coverage

You may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

You, your spouse, or your dependent child(ren) must notify the Plan Administrator or its delegate in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days after the later of (1) the date of the Qualifying Event or (2) the date on which coverage is lost under the Plan because of the event. After receiving notice of a Qualifying Event, the Plan Administrator will provide Qualifying Beneficiaries with an election notice, which describes the right to COBRA continuation coverage and how to make an election. Notice to your spouse is deemed notice to your covered dependents that reside with the spouse.

You or your dependent(s) are responsible for notifying the Plan Administrator or its delegate if you or your dependent(s) become covered under another group health plan or entitled to Medicare.

Election Procedures and Deadlines

A Qualified Beneficiary may make an election for COBRA continuation coverage if they are not covered under the Plan as a result of another Qualified Beneficiary's COBRA continuation election. To elect COBRA continuation coverage, you must complete the applicable election form within 60 days from the later of (1) the date the election notice was provided to you or (2) the date that the Qualified Beneficiary would otherwise lose coverage under the Plan due to the Qualifying Event and submit it to the Plan Administrator or its delegate. If the Qualified Beneficiary does not return the election form within the 60-day period, it will be considered a waiver of their COBRA continuation coverage rights.

Cost of COBRA Continuation Coverage

The cost of COBRA continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage.

When Continuation Coverage Ends

You may be able to continue coverage under the Health FSA until the end of the Plan Year in which the Qualifying Event occurs. However, COBRA continuation coverage may end earlier for any of the following reasons:

- You fail to make a required COBRA continuation coverage contribution;
- The date that you first become covered under another Health FSA;
- The date that you first become entitled to Medicare; or
- The date the Company no longer provides a Health FSA to any of its employees.

YOUR RIGHTS UNDER ERISA

As a participant in the Health FSA under this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants in a plan governed by ERISA shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants in plans governed by ERISA, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Company, your union, if applicable, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining an ERISA welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for an ERISA welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of ERISA plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court if you have exhausted the Plan's claims procedures. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court if you have exhausted the Plan's claims procedures. If you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

MISCELLANEOUS

FMLA

If you go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving health care benefits. Contact the Plan Administrator for more information under the Plan.

Unclaimed Reimbursements

Payments from the Account that are not claimed on a timely basis (for example, checks issued from the Plan that are not timely cashed) will be forfeited and returned to the Plan. Please contact your Plan Administrator about what constitutes "timely" claims of payment from the Plan.

Excess Payments/Reimbursements

If you receive an excess benefit or payment under the Plan, you must immediately repay any such excess payments/reimbursements. You must also reimburse the Company for any liability the Company may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable to you under this Plan.

Beneficiaries

If you die, your beneficiaries or your estate may submit claims for eligible expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose. If you do not name a beneficiary, the Plan Administrator may pay any amount to your

spouse, one or more of your dependents, or a representative of your estate.

Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO). You may obtain a copy of the QMCSO procedures from the Plan Administrator, free of charge.

Loss of Benefit

You may lose all or part of your Account(s) under the Plan if the unused balance is forfeited at the end of a Plan Year and if we cannot locate you when your benefit becomes payable to you.

Non-Alienation of Benefits

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a beneficiary to receive benefits under the Plan in the event of your death.

Amendment and Termination of the Plan

The Company may amend or terminate the Plan at any time.

Plan Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding on all persons and parties.

Taxation

The Company intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, the Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

Governing Law

The Plan is governed by the laws of Pennsylvania to the extent not pre-empted by Federal law.

PLAN INFORMATION

1. The Plan Sponsor and Plan Administrator is Middle Bucks Institute of Technology.

2. The Plan Sponsor's and Plan Administrator's Address is 2740 York Road, Jamison, Pennsylvania 18929

3. The Plan sponsor's EIN is 231701582

4. The Plan Sponsor and Plan Administrator's phone number is 215-343-2480

5. The Plan is a cafeteria plan under section 125 of the Internal Revenue Code. The Health FSA Benefit under the Plan is a welfare benefit plan.

6. The Plan number is 501.

7. The Plan's designated agent for service of legal process is the Plan Sponsor. Any legal papers should be delivered to the Plan Sponsor at the address listed above. However, service may also be made upon the Plan Administrator.

8. The Plan Year is the 12-consecutive month period ending on 06/30.

9. Amount contributed by Plan Participants and the Company to the Plan are general assets of the Company. All payments of benefits under the Plan are made solely out of the general assets of the Company. The Company has no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. The Company may, in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making benefit payments under this Plan.

BASIC PLAN DOCUMENT #125

CBIZ

TABLE OF CONTENTS

ARTICLE 1. INTRODUCTION

Section 1.01 PLAN

This document ("Basic Plan Document") and its related Adoption Agreement are intended to qualify as a cafeteria plan within the meaning of Code section 125. To the extent provided in the Adoption Agreement, the Plan provides for the pre-tax payment of premiums and contributions to spending accounts that are excludable from gross income under Code section 125, reimbursement of certain medical expenses that are excludable from gross income under Code section 105(b), reimbursement of certain dependent care expenses that are excludable from gross income under Code section 129, reimbursement of certain adoption expenses that are excludable from gross income under Code section 137, and/or for such other benefits as set forth herein.

Section 1.02 APPLICATION OF PLAN

Except as otherwise specifically provided herein, the provisions of this Plan shall apply to those individuals who are Eligible Employees of the Employer on or after the Effective Date. Except as otherwise specifically provided for herein, the rights and benefits, if any, of former Eligible Employees of the Employer whose employment terminated prior to the Effective Date, shall be determined under the provisions of the Plan, as in effect from time to time prior to that date.

ARTICLE 2. DEFINITIONS

Account means
the bookkeeping balance of an account established for each Participant as of the applicable date. "Account" or "Accounts" shall include, to the extent provided in the Adoption Agreement, a Premium Conversion Account, a General Purpose Health Flexible Spending Account, an HSA-Compatible Health Flexible Spending Account, a Dependent Care Assistance Plan Account, an Adoption Assistance Flexible Spending Account and such other account(s) or subaccount(s) as the Plan Administrator, in its discretion, deems appropriate.

Adoption Agreement means
the document executed in conjunction with this Basic Plan Document that contains the optional features selected by the Plan Sponsor.

Adoption Assistance Flexible Spending Account or Adoption Assistance FSA means
the Account established with respect to the Participant's election to have Adoption Expenses reimbursed by the Plan pursuant to Article 10.

Adoption Expenses means
the expenses described in Section 10.05(b)(2).

Affiliate means
the Plan Sponsor or any other employer required to be aggregated with the Plan Sponsor under Code sections 414(b), (c), (m) or (o); provided, however, that "Affiliate" shall not include any entity or unincorporated trade or business prior to the date on which such entity, trade or business satisfies the affiliation or control tests described above.

Benefits means
the benefit options available to Eligible Employees under the Plan.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code means
the Internal Revenue Code of 1986, as amended from time to time.

Compensation means
the cash wages or salary paid to a Participant. If the Adoption Agreement indicates that the Plan is a simple cafeteria plan as defined in Code section 125(j), "Compensation" shall mean Section 414(s) Compensation (defined below).

Contract means
an insurance policy, contract or self-funded arrangement under which a Participant is eligible to receive benefits regardless of whether such policy, contract or arrangement is related to any benefit offered hereunder. "Contract" shall not include any product which is advertised, marketed, or offered as long-term care insurance. "Contract" shall not include any qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an exchange established under section 1311 of such Act unless the Employer is a qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) offering the Employee the opportunity to enroll through such exchange in a qualified health plan in a group market.

Dependent means
an individual who qualifies as a dependent of a Participant under Code section 152 (as modified by Code section 105(b)). For purposes of the Premium Conversion Account, "Dependent" does not include any individual who is not a dependent under the underlying Contract. A child who is determined to be a Participant's alternate recipient under a qualified medical child support order under ERISA section 609 shall be considered a Dependent under this Plan, as applicable.

Dependent Care Assistance Plan Account or DCAP Account means
the Account established with respect to the Participant's election to have dependent care expenses reimbursed by the Plan pursuant to Article 8.

Effective Date shall have the meaning
set forth in Part A of the Adoption Agreement, provided that when a provision of the Plan states another effective date, such stated specific effective date shall apply as to that provision.

Eligible Employee means
any Employee employed by an Employer, subject to the modifications and exclusions described in the Adoption Agreement. If an individual is subsequently reclassified as, or determined to be, an Employee by a court, the Internal Revenue Service or any other governmental agency or authority, or if the Employer is required to reclassify such individual an Employee as a result of such reclassification determination (including any reclassification by the Employer in settlement of any claim or action relating to such individual's employment status), such individual shall not become an Eligible Employee by reason of such reclassification or determination.

An individual who becomes employed by an Employer in a transaction between the Employer and another entity that is a stock or asset acquisition, merger, or other similar transaction involving a change in the employer of the employees of the other entity shall not become eligible to participate in the Plan until the Employer or Plan Sponsor specifically authorizes such participation.

Employee means
any individual who is a common-law employee of an Employer, a leased employee as described in Code section 414(n), or full-time life insurance salesman as defined in Code section 7701(a)(20). The term "Employee" shall not include: (i) a self-employed individual (including a partner) as defined in Code section 401(c), or (ii) any person who owns (or is considered as owning within the meaning of Code section 318) more than 2 percent of the outstanding stock or combined voting power of an S corporation.

Employer means
the Plan Sponsor and any other entity that has adopted the Plan with the approval of the Plan Sponsor.

ERISA means
the Employee Retirement Income Security Act of 1974, as amended from time to time.

Flex Credits means
the Employer contributions described in Section 11.01 of the Plan.

FMLA means
the Family and Medical Leave Act of 1993 as amended from time to time.

Grace Period means
the designated period following a Plan Year during which a Participant who has unused benefits or contributions relating to a Benefit (for example, a Health FSA or DCAP Account) from the immediately preceding Plan Year and who incurs expenses for that same Benefit during the period, may be paid or reimbursed for those expenses as if the expenses had been incurred in the immediately preceding Plan Year.

General Purpose Health Flexible Spending Account or General Purpose Health FSA means
the Account established with respect to the Participant's election to have medical expenses reimbursed by the Plan pursuant to Article 6.

Health Flexible Spending Account or Health FSA means
the General Purpose Health FSA and/or HSA-Compatible Health FSA established with respect to the Participant's election to have medical expenses reimbursed by the Plan pursuant to Article 6 and Article 7.

Health Savings Account or HSA means
a health savings account established pursuant to Article 9.

Highly Compensated Employee means
an Employee described in Code section 414(q).

Highly Compensated Individual means
an individual within the meaning of Code section 105(h)(5).

HIPAA means
the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

HRA means
a health reimbursement arrangement subject to Code section 105.

HSA-Compatible Health Flexible Spending Account or HSA-Compatible Health FSA means
a Limited Purpose Health Flexible Spending Account and/or a Post-Deductible Health Flexible Spending Account.

Key Employee means
an Employee described in Code section 416(i).

Leased Employee means
an Employee described in Code section 414(n)(2).

Limited Purpose Health Flexible Spending Account or Limited Purpose Health FSA means
the Account established with respect to the Participant's election to have medical expenses, as described in Section 7.05(b)(1), reimbursed by the Plan pursuant to Article 7.

Qualified Plan means
the retirement plan sponsored by an Employer and identified in the Adoption Agreement.

Participant means
an Eligible Employee who participates in the Plan in accordance with Articles 3 and 4.

Plan means
the plan as identified in Part A.2 of the Adoption Agreement and as described in this Basic Plan Document and Adoption Agreement.

Plan Administrator means
the person(s) designated pursuant to the Adoption Agreement and Section 14.01.

Plan Sponsor means
the entity described in the Adoption Agreement that maintains the Plan.

Plan Year means
the 12-consecutive month period described in Part A of the Adoption Agreement.

Post-Deductible Health Flexible Spending Account or Post-Deductible Health FSA means

the Account established with respect to the Participant's election to have medical expenses, as described in Section 7.05(b)(2), reimbursed by the Plan pursuant to Article 7.

Premium Conversion Account means
the Account established with respect to the Participant's election to have premiums reimbursed by the Plan pursuant to Article 5.

PTO means
elective paid time off that must be used or forfeited by the last day of the Plan Year in which it was awarded.

Salary Reduction Agreement means
the agreement pursuant to which an Eligible Employee elects to reduce his or her Compensation and instead receive a Benefit provided under the Plan.

Section 414(s) Compensation means
compensation as defined in Code section 414(s) and Treas. Reg. section 1.414(s)-1. The period used to determine an Employee's compensation for a Plan Year must be either the Plan Year or the calendar year ending within the Plan Year. Whichever period is selected by the Plan Administrator must be applied uniformly to determine the compensation of every Eligible Employee under the Plan for that Plan Year. The Plan Administrator may, however, limit the period taken into account under either method to that portion of the Plan Year or calendar year in which the Employee was an Eligible Employee, provided that this limit is applied uniformly to all Eligible Employees.

Termination and Termination of Employment means
any absence from service that ends the employment of an Employee with the Employer.

ARTICLE 3. ELIGIBILITY

An Eligible Employee is an Employee who meets the age and service requirements set forth in the Adoption Agreement and who is not excluded pursuant to (a) Section 3.02, (b) the provisions governing the applicable Benefit below, or (c) the Adoption Agreement. An Eligible Employee may elect to participate in the Plan in accordance with Article 4.

Eligible Employees who were eligible to participate in the Plan immediately prior to the Effective Date shall be eligible to participate in the Plan on the Effective Date. Notwithstanding the foregoing, an Eligible Employee shall be eligible to make elections only for the Accounts as are specifically authorized in the Adoption Agreement.

Section 3.02 INELIGIBLE EMPLOYEES

Notwithstanding anything herein to the contrary, the Employees identified in the Adoption Agreement as such are not Eligible Employees and may not participate in any Benefit under the Plan.

Section 3.03 LEAVE OF ABSENCE

(a) FMLA Leave of Absence.
   (1) *Health Benefits.* If a Participant takes a leave of absence under FMLA, the Participant shall be entitled to continue to participate in those Benefits under the Plan that provide health care, including the Premium Conversion Account for payment of premiums applicable to health care, the Health FSA, and Flex Credits. A Participant may also elect to revoke coverage during an unpaid FMLA leave of absence or continue coverage but discontinue contributions for the period of the FMLA leave of absence, as set forth in the Adoption Agreement. If a Participant elects to revoke coverage during the unpaid FMLA leave of absence, the coverage will be reinstated under the same terms upon the Participant's return from the FMLA leave of absence.
   (2) *Non-Health Benefits.* A Participant shall not be entitled to continue to participate in Benefits under the Plan that do not provide health care except to the extent provided in the Adoption Agreement or in accordance with the Employer's established policy for providing such Benefits when an Employee is on non-FMLA leave. Participant contributions for Benefits during a leave of absence under FMLA shall be determined by the Plan Administrator in accordance with Code section 125.
   (3) *Non-FMLA Leave of Absence.* If a Participant takes an unpaid leave of absence other than under FMLA, the Participant shall not be entitled to continue to participate in Benefits under the Plan except to the extent provided in the Adoption Agreement or in

accordance with the Employer's established policy for providing such Benefits when an Employee is on non-FMLA leave.

(4) *USERRA.* If a Participant is on a leave of absence in the uniformed services under the Uniformed Services Employment and Reemployment Rights Act (USERRA), the Participant shall be entitled to elect to continue participation in the Premium Conversion Account and Health FSA for the lesser of (i) 24 months, beginning on the date the Participant's absence began and (ii) the date the Participant fails to apply for or return to employment with the Employer, as determined under USERRA.

(5) *Applicable State Law.* The Plan Administrator shall permit a Participant to continue Benefits under the Plan as required under any applicable state law to the extent that such law is not pre-empted by federal law.

(6) *Paid Leave of Absence.* A Participant shall not be entitled to revoke participation in any Benefits during a paid leave of absence except in accordance with Article 4.

Section 3.04 TERMINATION OF PARTICIPATION

If a Participant remains an Employee but is no longer an Eligible Employee (e.g., due to a change in job classification), his or her participation in the Plan shall terminate on the date on which the Participant ceases to be an Eligible Employee, unless provided otherwise herein or in the Adoption Agreement. Should such Employee again qualify as an Eligible Employee, he or she shall be eligible to participate in the Plan as of the first day of the subsequent Plan Year, unless earlier participation is required by applicable law or permitted pursuant to Section 4.03.

Section 3.05 TERMINATION OF EMPLOYMENT

If a Participant has a Termination of Employment, his or her participation in the Plan shall be governed in accordance with the terms of the applicable Benefit as provided herein.

Section 3.06 REEMPLOYMENT

(a) Except as otherwise provided in the Adoption Agreement, the Plan Administrator shall automatically reinstate Benefit elections for Eligible Employees who are rehired by an Employer within 30 days of a Termination. If an Employee has a Termination of Employment and is subsequently reemployed by the Employer as an Eligible Employee more than 30 days following the date of Termination, the Plan Administrator may allow the Eligible Employee to elect to reinstate the Benefit election in effect at the time of Termination or to make a new election under the Plan, unless otherwise provided herein or in the Adoption Agreement.

(b) *Ineligible Employees.* An Employee who has a Termination of Employment and who is subsequently reemployed by the Employer but is not an Eligible Employee shall be eligible to participate on the date the individual becomes an Eligible Employee and, at that time, may elect to participate in the Plan in accordance with Article 4.

ARTICLE 4. BENEFITS AND PARTICIPATION

Section 4.01 BENEFIT OPTIONS

Each Participant may elect to participate in the following Benefits to the extent selected in the Adoption Agreement, pursuant to the applicable Article herein:

(a) Premium Conversion Account
(b) General Purpose Health Flexible Spending Account
(c) HSA-Compatible Health Flexible Spending Account
(d) Dependent Care Assistance Plan Account
(e) Adoption Assistance Flexible Spending Account
(f) Health Savings Account
(g) PTO Purchase/Sale
(h) 401(k) Plan Contributions
(i) Flexible Benefit Credits

Section 4.02 ELECTION TO PARTICIPATE

(a) *Elections to Participate.* The Plan Administrator shall prescribe such forms and may require such data from an Eligible Employee as are reasonably required and permitted under applicable law to enroll the Eligible Employee in the Plan or to effectuate any elections made

pursuant to this Article 4. The Plan Administrator may adopt procedures governing the elections described in this Article 4, including, without limitation, a minimum annual and per pay-period contribution amount, a maximum contribution per pay-period amount consistent with applicable annual limits, and the ability of a Participant to make after-tax contributions to the Plan.

(b) *New Employees.* An Eligible Employee may elect to participate in the Benefits under the Plan during the period established by the Plan Administrator, which shall be no longer than 30 days after the date the Eligible Employee becomes an Employee. The election will be effective as of the Employee's hire date; provided, however, that amounts used to pay for such election must be made from Compensation not yet currently available on the date of the election.

(c) *Newly Eligible Employees.* An Employee who becomes an Eligible Employee (for example, after satisfying the Plan's age and/or service requirements, if any) may elect to participate in the Benefits under the Plan during the period established by the Plan Administrator, which shall be no longer than 31 days after the date the Employee becomes an Eligible Employee. The election will be effective on a prospective basis.

(d) *Continuing Eligible Employees.* An Eligible Employee may elect to enroll in the Plan or to modify or revoke his or her election during the period established by the Plan Administrator that precedes the Plan Year for which the election will be effective, except as provided in Article 9 and Article 10.

(e) *Failure to Elect.* If an Eligible Employee does not make an election in accordance with the required enrollment procedures with respect to any or all Benefits under the Plan, the Eligible Employee will be deemed to have elected not to participate in such Benefit for the applicable Plan Year, except as otherwise provided herein or specified in the Adoption Agreement.

Section 4.03 MID-YEAR ELECTION CHANGES

An Eligible Employee's election to participate in a Benefit, other than an HSA, hereunder is irrevocable during the Plan Year, except that an Eligible Employee may change his or her election during the Plan Year no later than the end of the 31-day period beginning on the date of a Change in Status, unless provided otherwise in the Adoption Agreement. The election change must be on account of and correspond with a Change in Status that affects eligibility for coverage under the Plan.

A "Change in Status" means events described in Treasury Regulation section 1.125-4. Change in Status includes, but is not limited to, the following, to the extent provided in the Adoption Agreement:

(a) *Legal Marital Status.* Events that change an Eligible Employee's legal marital status, including marriage, death of spouse, divorce, legal separation, and annulment.

(b) *Number of Dependents.* Events that change an Eligible Employee's number of Dependents, including birth, death, adoption, and placement for adoption.

(c) *Employment Status.* Any of the following events that change the employment status of the Eligible Employee, the Eligible Employee's spouse, or the Eligible Employee's Dependent: a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, and a change in worksite. In addition, if the eligibility conditions of the Plan or other employee benefit plan of the Employer of the Eligible Employee or the Eligible Employee's Spouse or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the applicable plan, then that change constitutes a change in employment under this paragraph (c).

(d) *Dependent satisfies or ceases to satisfy eligibility requirements.* Events that cause an Eligible Employee's Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.

(e) *Residence.* A change in the place of residence of the Eligible Employee or the Eligible Employee's spouse or Dependent.

(f) *Adoption Assistance.* For purposes of adoption assistance provided through the Plan, the commencement or termination of an adoption proceeding.

(g) *COBRA.* If the Eligible Employee or the Eligible Employee's spouse or Dependent becomes eligible for continuation coverage under an Employer's group health plan as provided in Code section 4980B or any similar state law, the Eligible Employee may elect to increase contributions to his or her Premium Conversion Account under the Plan in order to pay for the continuation coverage.

(h) *Court Order.* A judgment, decree, or other order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order as defined in ERISA section 609) that requires accident or health coverage for an Eligible Employee's child or for a foster child who is a Dependent of the employee. The Eligible Employee may change his or her election to provide coverage for the child if the order requires coverage for the child under the Plan and may cancel coverage under the Plan for the child if the order requires the Eligible Employee's spouse, former spouse, or other individual to provide coverage for the child, and that coverage is, in fact, provided.

(i) *Entitlement to Medicare or Medicaid.* If an Eligible Employee or an Eligible Employee's spouse or Dependent who is enrolled in an Employer's accident or health plan becomes enrolled under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Eligible Employee may make a prospective election change to cancel or reduce

coverage of that Employee, spouse, or Dependent under the Employer-sponsored accident or health plan. In addition, if an Eligible Employee or an Eligible Employee's spouse or Dependent who has been enrolled in such coverage under Medicare or Medicaid loses eligibility for such coverage, the Eligible Employee may make a prospective election to commence or increase his or her coverage or the coverage of his or her spouse or Dependent, as applicable, under the Employer-sponsored accident or health plan.

(j) *Significant Cost or Coverage Changes.*

(1) *Automatic Changes.* If the cost of an Employer-sponsored Contract premium increases (or decreases) during a period of coverage and, under the terms of the Contract, Eligible Employees are required to make a corresponding change in their payments, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in affected Eligible Employees' elective contributions for the Plan.

(2) *Significant Cost Changes.* If the cost charged to an Eligible Employee for a Contract benefit package option significantly increases or significantly decreases during a period of coverage, the Plan may permit the Eligible Employee to make a corresponding change in an election under the Plan. Changes that may be made include commencing participation in the Plan for the option with a decrease in cost, or, in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis coverage under another benefit package option providing similar coverage or dropping coverage if no other benefit package option providing similar coverage is available. For example, if the cost of an indemnity option under an accident or health plan significantly increases during a period of coverage, Eligible Employees who are covered by the indemnity option may make a corresponding prospective increase in their payments or may instead elect to revoke their election for the indemnity option and, in lieu thereof, elect coverage under another benefit package option including an HMO option (or drop coverage under the accident or health plan if no other benefit package option is offered).

A cost increase or decrease refers to an increase or decrease in the amount of the elective contributions under the Plan, whether that increase or decrease results from an action taken by the Eligible Employee (such as switching between full-time and part-time status) or from an action taken by an Employer (such as reducing the amount of Employer contributions for a class of Eligible Employees).

This paragraph (j) applies in the case of the Dependent Care Assistance Plan Account only if the cost change is imposed by a Dependent care provider who is not a relative of the Eligible Employee as described in Code section 152(a)(1) through (8), incorporating the rules of Code section 152(b)(1) and (2). This paragraph (j) does not apply to Health FSAs.

(k) *Significant Curtailment Without Loss of Coverage.* If an Eligible Employee or an Eligible Employee's spouse and/or Dependent has a significant curtailment of coverage under a Contract during a period of coverage that is not a loss of coverage as described in paragraph (l) of this section (for example, there is a significant increase in the deductible, the copay, or the out-of-pocket cost sharing limit under the Contract), the Eligible Employee may revoke his or her election for that coverage and, in lieu thereof, elect to receive on a prospective basis coverage under another benefit package option providing similar coverage. This paragraph (k) does not apply to Health FSAs.

(l) *Significant Curtailment With Loss of Coverage.* If an Eligible Employee (or an Eligible Employee's spouse or Dependent) has a significant curtailment that is a loss of coverage, the Eligible Employee may revoke his or her election under the Plan and, in lieu thereof, elect either to receive on a prospective basis coverage under another benefit package option providing similar coverage or to drop coverage if no similar benefit package option is available. For purposes of this paragraph (l), a loss of coverage means:

(1) a complete loss of coverage under the benefit package option or other coverage option (including the elimination of a benefits package option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation);

(2) a substantial decrease in the medical care providers available under the Contract (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO);

(3) a reduction in the benefits for a specific type of medical condition or treatment with respect to which the Eligible Employee or the Eligible Employee's spouse or Dependent is currently in a course of treatment; or

(4) any other similar fundamental loss of coverage as determined by the Plan Administrator's in its sole discretion.

This paragraph (l) does not apply to Health FSAs.

(m) *Addition or Improvement of a Benefit Package Option.* If the Plan or a Contract adds a new benefit package option or other coverage option, or if coverage under an existing benefit package option or other coverage option is significantly improved during a period of coverage, an Eligible Employee may revoke his or her election under the Plan and, in lieu thereof, to make an election on a prospective basis for coverage under the new or improved benefit package option. This paragraph (m) does not apply to Health FSAs.

(n) *Change in Coverage Under Another Employer Plan.* An Eligible Employee may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including another plan of the Employer or of another employer) if -

(1) The other cafeteria plan or qualified benefits plan permits participants to make an election change that would be permitted under paragraphs (a) through (o) of this section (disregarding this paragraph (n)(1)); or

(2) This Plan permits Eligible Employees to make an election for a Plan Year that is different from the period of coverage under the other cafeteria plan or qualified benefits plan.

This paragraph (n) does not apply to Health FSAs.

(o) *FMLA.* If a Participant contributes to the cost of such Benefit, he or she may revoke coverage or continue coverage but discontinue payment of his or her share of the cost of a Benefit that provides group health plan coverage (including a Health FSA) during the period of a leave of absence under FMLA. An Eligible Employee who revokes coverage shall be entitled to reinstate coverage upon returning from a leave of absence under FMLA.

(p) *Loss of Coverage Under Other Group Health Coverage.* An Eligible Employee may make an election on a prospective basis to add coverage under the Plan for the Eligible Employee and/or the Eligible Employee's spouse and/or Dependent if the Eligible Employee and/or the Eligible Employee's spouse and/or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including a State's children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in section 7701(a)(40)), the Indian Health Service, or a tribal organization; a State health benefits risk pool; or a Foreign government group health plan. This paragraph (p) does not apply to Health FSAs.

(q) *Revocation due to Reduction in Hours of Service.* A Participant may prospectively elect to cancel contribution for and payment of the Employee-paid portion of the Employer-sponsored group health plan Contract premiums if (1) the Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the Employer-sponsored group health plan and (2) the revocation of the election of coverage under the Employer-sponsored group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

(r) *Enrollment in a Qualified Health Plan.* A Participant may prospectively elect to cancel contribution for and payment of the employee-paid portion of the Employer-sponsored group health plan Contract premiums if (1) the Participant is eligible for a special enrollment period to enroll in a "qualified health plan" through a competitive marketplace established under Section 1311 of the Patient Protection and Affordable Care Act ("Marketplace") or the Employee seeks to enroll in a qualified health plan through a Marketplace during the Marketplace's annual open enrollment period.

The Plan Administrator reserves the right to determine whether an Eligible Employee has experienced a Change in Status and whether the Eligible Employee's requested election is consistent with such Change in Status.

ARTICLE 5. PREMIUM CONVERSION ACCOUNT

Section 5.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Premium Conversion Accounts, an Employee may elect to have a portion of his or her Compensation applied by the Employer toward the Premium Conversion Account. The Account established under this Article 5 is intended to qualify under Code sections 79 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

Section 5.02 ELIGIBLE EMPLOYEES

All Employees are eligible to participate in the Premium Conversion Account, except as otherwise specified in the Adoption Agreement.

Section 5.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the Premium Conversion Account in accordance with Article 4. Except as otherwise provided in the Adoption Agreement, all Employees will automatically be enrolled in the Premium Conversion Account and will be deemed to have elected to contribute the entire amount of any premiums payable by the Employee for participation in Employer-sponsored Contract(s) unless he or she affirmatively elects otherwise in accordance with Section 4.02.

(b) *Contributions.* A Participant's Premium Conversion Account will be credited with amounts withheld from the Participant's Compensation. The amount of a Participant's contribution to the Premium Conversion Account shall be equal to the amount of the Participant's portion of the premium on the applicable Contract. Except as elected in the Adoption Agreement, if the amount of the Participant's portion of the applicable premium on the Contract increases or decreases, the Participant's contribution to the Premium Conversion Account will automatically be adjusted to reflect the increase or decrease.

(c) *Failure to Elect.* Except as provided in the Adoption Agreement, an Eligible Employee who fails to submit a Salary Reduction

Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to a Premium Conversion Account for the Plan Year with respect to non-Employer sponsored Contracts, regardless of the election he or she had in effect for the prior Plan Year. In addition, an Eligible Employee who affirmatively elected not to participate in the Premium Conversion Account for the Plan Year with respect to Employer-sponsored Contracts will not be enrolled in the Premium Conversion Account for any Plan Year until he or she affirmatively elects to participate in the Premium Conversion Account with respect to Employer-sponsored Contracts in accordance with Article 4.

Section 5.04 ELIGIBLE EXPENSES

A Participant's Premium Conversion Account will be debited for amounts applied to the Employee-paid portion of the applicable Contract premiums. The Plan Administrator will not direct the Employer to pay any premium on a Contract to the extent such payment exceeds the balance of a Participant's Premium Conversion Account.

Contributions to the Premium Conversion Account for Code section 79 coverage (group term life insurance) shall be made on an after-tax basis to the extent that the premiums relate to coverage in excess of the limit described in Code section 79(a).

Section 5.05 TERMINATION OF EMPLOYMENT

Upon a Participant's Termination of Employment, the Participant's contributions to the Premium Conversion Account will cease, except with respect to contributions for COBRA continuation coverage under the Employer-sponsored Contract, if applicable. Coverage under the applicable Contract may continue in accordance with the terms of the Contract for the remainder of the period of coverage with respect to which the required Contract premium has been paid.

ARTICLE 6. HEALTH FLEXIBLE SPENDING ACCOUNT

Section 6.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Health Flexible Spending Accounts, an Eligible Employee may elect to participate in a General Purpose Health Flexible Spending Account in accordance with this Article 6. The Account established under this Article 6 is intended to qualify as a health flexible spending arrangement under Code sections 105 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

Section 6.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 are eligible to participate in the General Purpose Health Flexible Spending Account, except as otherwise specified in the Adoption Agreement. An Employee who is not eligible to participate in an Employer-sponsored group health plan is not eligible to participate in the General Purpose Health Flexible Savings Account. An Eligible Employee who has elected to participate in the HSA Benefit and/or the HSA-Compatible Health FSA Benefit is not eligible to participate in the General Purpose Health FSA Benefit under this Article 6.

Section 6.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the General Purpose Health FSA and elect to have a portion of his or her Compensation contributed to a General Purpose Health FSA in accordance with Article 4. A Health FSA election is irrevocable for the Plan Year except in the event of a Change in Status as provided in Section 4.03.
(b) *Contributions.* A Participant's General Purpose Health FSA will be credited with amounts withheld from the Participant's Compensation and any amounts contributed by the Employer pursuant to the Adoption Agreement.
(c) *Failure to Elect.* Except as provided in the Adoption Agreement, an Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to a General Purpose Health FSA for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 6.04 LIMITS

(a) The amount of an Eligible Employee's contribution to a Health Flexible Spending Account shall not exceed the maximum annual limit described in the Adoption Agreement, and in no event shall exceed the limitations set forth in Code section 125(i), as adjusted. The Code

section 125(i) limit is reduced by the amount of Flex Credits, if any, that a Participant may elect to receive in cash as set forth in the Adoption Agreement or as a taxable benefit.

(b) Employer contributions to a Participant's Health FSA will not exceed the greater of (a) two times the amount elected in the Participant's Salary Reduction Agreement to be contributed to the Health FSA for the Plan Year, including Flex Credits the Participant elects to contribute to the Health FSA, if applicable or, (b) $500 plus the amount elected in the Participant's Salary Reduction Agreement and any Flex Credits contributed to the Health FSA. If the Plan provides for Flex Credits but does not allow the cash out of the Flex Credits, the maximum amount of Flex Credits that a Participant can elect contribute to the Health FSA shall be treated as an Employer contribution for purposes of this Section 6.04(b).

Section 6.05 ELIGIBLE EXPENSES

(a) *Debits from the Health FSA.* A Participant's Health FSA will be debited for expenses described in this Section 6.05. The entire annual amount elected by the Eligible Employee on the Salary Reduction Agreement for the Plan Year for the Health FSA, less any reimbursements already disbursed from the General Purpose Health FSA, shall be available to the Participant at any time during the Plan Year without regard to the balance in the General Purpose Health FSA, provided that the amounts elected in the Salary Reduction Agreement have been contributed to date as provided in the Salary Reduction Agreement.

(b) *Eligible Expenses.* Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her General Purpose Health FSA for expenses that are: (i) incurred in the Plan Year (or Grace Period, if applicable), (ii) incurred while he or she is a Participant in the Plan, and (iii) excludable under Code section 105(b); provided that such expenses are not covered, paid or reimbursed from any other source. For purposes of determining whether an expense is excludable under Code section 105(b), the following applies:

(1) *Michelle's Law.* "Dependents" shall also include students who have not attained the age of 24 for whom coverage is required under Code section 9813; provided, that treatment as a dependent due to a medically necessary leave of absence under Code section 9813 shall not extend beyond a period of one year.

(2) *Coverage of Adult Children.* Expenses for a child (as defined in Code section 152(f)(1)) of the Participant may be covered until the child's 26th birthday or, if provided for in the Adoption Agreement, until the end of the calendar year in which the child turns age 26.

Section 6.06 REIMBURSEMENT

(a) *Period for Reimbursement.* The Plan Administrator shall direct the reimbursement from a Participant's General Purpose Health FSA for eligible expenses incurred during the Plan Year. If the Adoption Agreement so provides, the unused contributions that remain in a Participant's General Purpose Health FSA at the end of a Plan Year may be used to reimburse expenses that are incurred during a Grace Period beginning on the first day of the subsequent Plan Year and ending no later than the fifteenth day of the third calendar month of such Plan Year, in accordance with Prop. Treas. Reg. section 1.125-1(e), as amended or superseded. No claims incurred during a Grace Period shall be reimbursed from a General Purpose Health FSA if the Plan permits carry over of General Purpose Health FSA balances under Section 6.07(b).

(b) *Period for Submitting Claims.* A Participant may submit a request for reimbursement from his or her General Purpose Health FSA during the Plan Year and no later than the date specified in the Adoption Agreement. The claim must be made in the manner required by the Plan Administrator.

(c) *Payment of Claims.* To the extent that the Plan Administrator approves the claim, the Employer shall: (i) reimburse the Participant or, (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from General Purpose Health FSA. The Plan Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. Notwithstanding the foregoing payment schedule, the Plan Administrator may provide that payments/reimbursements from the General Purpose Health FSA of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year (or Grace Period, if applicable) shall be reimbursed without regard to the minimum payment amount.

(d) *Coordination with HRA.* A Participant who is also eligible to participate in an HRA sponsored by the Employer shall not be entitled to payment/reimbursement under the General Purpose Health FSA for expenses that are reimbursable under both the General Purpose Health FSA and the HRA until the Participant has received his or her maximum reimbursement under the HRA. Notwithstanding the foregoing, a Participant shall be entitled to payment/reimbursement under the General Purpose Health FSA if, before the Plan Year begins, the plan document for the HRA specifies that coverage under the HRA is available only after expenses exceeding the applicable dollar amounts in the General Purpose Health FSA have been paid.

(e) *Automatic Payment.* If the Adoption Agreement so provides, a Participant who elects to receive coverage under a Contract that is offered in conjunction with an Employer-sponsored benefit plan may elect that any eligible expenses that are not covered under the applicable Contract, such as co-payments, co-insurance or deductibles, be automatically paid through his or her General Purpose Health

FSA.

(f) *Debit Card.* Subject to IRS guidelines, the Plan Administrator may provide for the use of debit or stored value cards for payment of eligible General Purpose Health FSA expenses.

Section 6.07 FORFEITURES

(a) *Forfeitures.* Any balance remaining in a Participant's General Purpose Health FSA at the end of any Plan Year subject to the carryover amount limit in subsection (b) below, if applicable (or after the Grace Period described in Section 6.06(a), if applicable), shall be forfeited and shall be used to (1) pay administrative expenses, (2) offset losses to the Health FSA due to reimbursements exceeding contributions for the Plan Year, (3) reduce the required salary reduction amounts for the next Plan Year, (4) reduce the required employer contributions for the next Plan Year, (4) reallocate to participants on a uniform basis, and/or (5) any other use allowed under all applicable laws and regulations. If the General Purpose Health FSA is not subject to ERISA, the forfeited amount can be returned to the Employer.

(b) *Carryovers.* Notwithstanding subsection (a), and to the extent selected in the Adoption Agreement, the Plan will carry over to the immediately following Plan Year up to $500 (as indexed) of any amount remaining unused as of the end of the Plan Year in a Participant's General Purpose Health FSA. The amount remaining unused as of the end of the Plan Year is the balance in the General Purpose Health FSA after all eligible expenses have been reimbursed and the claims deadline for the Plan Year has passed. The carryover amount may be used to pay or reimburse eligible expenses incurred during the Plan Year to which it is carried over. Any unused amount remaining in the General Purpose Health FSA in excess of $500 as indexed (or a lower amount specified in the Adoption Agreement) will be forfeited in accordance with subsection (a) above. The Plan Administrator may prescribe procedures for the carryover including, but not limited to, establishing a minimum amount for carryover and requiring a Participant to use the rollover in the following Plan Year, provided that any such procedure is non-discriminatory.

Section 6.08 CARRYOVER TO AN HSA-COMPATIBLE HEALTH FSA

If a Participant who has elected a General Purpose Health FSA for a given Plan Year establishes a Health Savings Account under the Plan or otherwise for the subsequent Plan Year, he or she may elect (or may be deemed by the Plan Administrator to have elected) as of the last day of the Plan Year (the "Conversion Date") to carryover the balance in his or her General Purpose Health FSA to an available HSA-Compatible Health FSA for the subsequent Plan Year if so elected in the Adoption Agreement. An HSA-Compatible Health FSA cannot be converted into a General Purpose Health FSA.

Section 6.09 TERMINATION OF EMPLOYMENT

Except as provided in the Adoption Agreement, contributions to a Participant's Health FSA shall cease upon Termination of Employment. Any balance remaining in a Participant's Health FSA on the date of his or her Termination of Employment shall be forfeited and shall remain the property of the Employer, except as expressly provided herein. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within 30 days following Termination of Employment, unless a different period for submitting claims following Termination of Employment is indicated in the Adoption Agreement.

Section 6.10 QUALIFIED RESERVIST DISTRIBUTIONS

(a) If the Adoption Agreement provides for Qualified Reservist Distributions, a Participant may receive a distribution of the portion of his General Purpose Health FSA specified in the Adoption Agreement. The distribution will only be made if: (i) such Participant was a member of a reserve component ordered or called to active duty for a period in excess of 179 days or for an indefinite period and (ii) such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of such order or call. A Qualified Reservist Distribution may not be made based on an order or call to active duty of any individual other than the Participant, including the spouse of the Participant.

(b) A Participant may submit General Purpose Health FSA claims for medical expenses incurred before the date a Qualified Reservist Distribution is requested. The Participant shall not have the right to submit claims for medical expenses incurred after the date such Qualified Reservist Distribution is requested. The Plan shall pay the Qualified Reservist Distribution to the Participant within a reasonable time, but not more than sixty days after the request for a Qualified Reservist Distribution has been made.

(c) This Subsection shall be construed in accordance with IRS Notice 2008-82 and any superseding guidance.

Section 6.11 SEPARATE PLAN

Although described within this document, the General Purpose Health FSA is a separate plan for purposes of administration and all reporting and

nondiscrimination requirements imposed by Code section 105. The General Purpose Health FSA is also a separate plan for purposes of ERISA, HIPAA, and COBRA, if applicable.

ARTICLE 7. HSA-COMPATIBLE HEALTH FLEXIBLE SPENDING ACCOUNT

Section 7.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Limited Purpose Health Flexible Spending Accounts and/or Post-Deductible Health Flexible Spending Accounts (collectively, "HSA-Compatible Health FSAs"), an Eligible Employee may elect to have a portion of his or her Compensation contributed to an HSA-Compatible Health FSA. The Account established under this Article 7 is intended to qualify as a health flexible spending arrangement under Code sections 105 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

Section 7.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 are eligible to participate in the HSA-Compatible Health FSA Benefit except as specified in the Adoption Agreement. An Employee who is not eligible to participate in Employer-sponsored group health plan is not eligible to participate in the HSA-Compatible Health FSA. A Participant who has elected the Health FSA under Article 6 is not eligible to elect an HSA-Compatible Health FSA except as otherwise provided in Section 6.08.

Section 7.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in an HSA-Compatible Health FSA in accordance with Article 4. An HSA-Compatible Health FSA election is irrevocable for the Plan Year except in the event of a Change in Status as provided in Section 4.03.

(b) *Contributions.* A Participant's HSA-Compatible Health FSA will be credited with amounts withheld from the Participant's Compensation and any amounts contributed by the Employer pursuant to the Adoption Agreement.

(c) *Failure to Elect.* Except as provided in the Adoption Agreement, an Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to an HSA-Compatible Health FSA for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 7.04 LIMITS

The amount of contribution to a Participant's HSA-Compatible Health FSA shall not exceed the maximum annual limit described in the Adoption Agreement, and in no event shall exceed the limitations set forth in Code section 125(i), as adjusted.

Section 7.05 ELIGIBLE EXPENSES

(a) *Debits from the HSA-Compatible Health FSA.* A Participant's HSA-Compatible Health FSA will be debited for expenses described in this Section 7.05. The entire annual amount elected by the Eligible Employee on the Salary Reduction Agreement for the Plan Year for the HSA-Compatible Health FSA, less any reimbursements already disbursed for the Plan, shall be available to the Participant at any time during the Plan Year without regard to the balance in the HSA-Compatible Health FSA, provided that the amounts elected in the Salary Reduction Agreement have been contributed to date as provided in the Salary Reduction Agreement.

(b) *Eligible Expenses.*

(1) *Limited Purpose Health FSA.* Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her Limited Purpose Health FSA for expenses that are: (i) incurred in the Plan Year (except as provided in Section 7.05(c)), (ii) incurred while the Participant participates in the Plan, (iii) excludable under Code section 105(b), (iv) incurred for dental or vision care or for preventive care (as defined under Code section 223(c)(2)(C), and (v) incurred for telehealth services as defined in Code section 223(c)(2)(E); provided that such expenses that are not covered, paid or reimbursed from any other source.

(2) *Post-Deductible Health FSA.* Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her Post-Deductible Health FSA for expenses that are: (i) incurred in the Plan Year (except as provided in Section 7.05(c)), (ii) incurred while the Participant participates in the Plan, (iii) excludable under Code section 105(b), and (iv) incurred after the Participant has satisfied the minimum annual deductible under Code section 223(c)(2)(A)(i), provided that such expenses that are not covered, paid or reimbursed from any other source.

(c) For purposes of determining whether an expense is excludable under Code section 105(b), the following applies:

(1) *Michelle's Law.* Unless otherwise provided in the Adoption Agreement, "Dependents" shall also include students who have not attained the age of 24 for whom coverage is required under Code section 9813; provided, that treatment as a Dependent due to a medically necessary leave of absence under Code section 9813 shall not extend beyond a period of one year.

(2) *Coverage of Adult Children.* Expenses for a child (as defined in Code section 152(f)(1)) of the Participant may be covered until the child's 26th birthday or, if provided for in the Adoption Agreement, until the end of the calendar year in which the child turns age 26.

Section 7.06 REIMBURSEMENT

(a) *Period for Reimbursement.* The Plan Administrator shall direct the reimbursement from a Participant's HSA-Compatible Health FSA for eligible expenses incurred during the Plan Year or as otherwise provided in the Adoption Agreement. If the Adoption Agreement so provides, the unused contributions that remain in an HSA-Compatible Health FSA at the end of a Plan Year may be used to reimburse expenses that are incurred during a "Grace Period" beginning on the first day of the subsequent Plan Year and ending no later than the fifteenth day of the third calendar month of such Plan Year, in accordance with Prop. Treas. Reg. section 1.125-1(e), as amended or superseded.

(b) *Period for Submitting Claims.* A Participant may submit a request for reimbursement from his or her HSA-Compatible Health FSA during the Plan Year and no later than the date specified in the Adoption Agreement. The claim must be made in the manner required by the Plan Administrator.

(c) *Substantiation of Claims.* A Participant's claim for reimbursement from a Post-Deductible Health FSA must include information from an independent third party that the deductible for his or her high-deductible health plan has been satisfied. A Participant's claims for reimbursement from a Limited-Purpose Health FSA must include information from an independent third-party that the medical expenses to be reimbursed are for vision care, dental care or preventive care.

(d) *Payment of Claims.* To the extent that the Plan Administrator approves the claim, the Employer shall: (i) reimburse the Participant, or (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from the HSA-Compatible Health FSA. The Plan Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. The Plan Administrator may provide that payments/reimbursements from the HSA-Compatible Health FSA of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year (or Grace Period, if applicable) shall be reimbursed without regard to the minimum payment amount.

(e) *Coordination with HRA.* A Participant who is also eligible to participate in ("an HRA") sponsored by the Employer shall not be entitled to payment/reimbursement under the HSA-Compatible Health FSA for expenses that are reimbursable under both the HSA-Compatible Health FSA and the HRA until the Participant has received his or her maximum reimbursement under the HRA. Notwithstanding the foregoing, a Participant shall be entitled to payment/reimbursement under the HSA-Compatible Health FSA if, before the Plan Year begins, the plan document for the HRA specifies that coverage under the HRA is available only after expenses exceeding the applicable dollar amounts in the HSA-Compatible Health FSA have been paid.

(f) *Automatic Payment.* If the Adoption Agreement so provides, a Participant who elects to receive coverage under a Contract that is offered in conjunction with an Employer-sponsored benefit plan may elect that any eligible expenses that are not covered under the applicable Contract, such as co-payments, co-insurance or deductibles, be automatically paid through his or her HSA-Compatible Health FSA.

(g) *Debit Card.* Subject to IRS guidelines, the Plan Administrator may provide for the use of debit or stored value cards for payment of eligible HSA-Compatible Health FSA expenses.

Section 7.07 FORFEITURES

(a) *Forfeitures.* Any balance remaining in a Participant's HSA-Compatible Health FSA at the end of any Plan Year, subject to the carryover amount limit in subsection (b) below, if applicable (or after the Grace Period described in Section 6.06(a), if applicable), shall be forfeited and shall be used to (1) pay administrative expenses, (2) offset losses to the Health FSA due to reimbursements exceeding contributions for the Plan Year, (3) reduce the required salary reduction amounts for the next Plan Year, (4) reduce the required employer contributions for the next Plan Year, (4) reallocate to participants on a uniform basis, and/or (5) any other use allowed under all applicable laws and regulations. If the HSA-Compatible Health FSA is not subject to ERISA, the forfeited amount can be returned to the Employer. Subject to Section 7.06(a) allowing for reimbursement of eligible expenses incurred during the Grace Period and subject to subsection (b) below, unused contributions to an HSA-Compatible Health FSA remaining at the end of a Plan Year may not be cashed-out or converted to any other taxable or nontaxable benefit.

(b) *Carryovers.* Notwithstanding subsection (a) and to the extent selected in the Adoption Agreement, the Plan will carry over to the immediately following Plan Year up to $500 (as indexed) of any amount remaining unused as of the end of the Plan Year in a Participant's

HSA-Compatible Health FSA. The amount remaining unused as of the end of the Plan Year is the balance in the HSA-Compatible Health FSA after all eligible expenses have been reimbursed and the claims deadline for the Plan Year has passed. The carryover amount may be used to pay or reimburse eligible expenses incurred during the entire Plan Year to which it is carried over. Any unused amount remaining in the HSA-Compatible Health FSA in excess of $500 as indexed (or a lower amount specified in the Adoption Agreement) will be forfeited in accordance with subsection (a) above. The Plan Administrator may prescribe procedures for the carryover including, but not limited to, establishing a minimum amount for carryover and requiring a Participant to use the carryover in the following Plan Year, provided that any such procedure is non-discriminatory.

Section 7.08 TERMINATION OF EMPLOYMENT

Except as provided in the Adoption Agreement, contributions to a Participant's HSA-Compatible Health FSA shall cease upon Termination of Employment. Any balance remaining in a Participant's HSA-Compatible Health FSA on the date of his or her Termination of Employment shall be forfeited and shall remain the property of the Employer, except as expressly provided herein. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within 30 days following Termination of Employment, unless a different period for submitting claims following Termination of Employment is indicated in the Adoption Agreement.

Section 7.09 QUALIFIED RESERVIST DISTRIBUTIONS

(a) If the Adoption Agreement provides for Qualified Reservist Distributions, a Participant may receive a distribution of the portion of his HSA-Compatible Health FSA specified in the Adoption Agreement. The distribution will only be made if: (i) such Participant was a member of a reserve component ordered or called to active duty for a period in excess of 179 days or for an indefinite period and (ii) such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of such order or call. A Qualified Reservist Distribution may not be made based on an order or call to active duty of any individual other than the Participant, including the spouse of the Participant.
(b) A Participant may submit HSA-Compatible Health FSA claims for medical expenses incurred before the date a Qualified Reservist Distribution is requested. The Participant shall not have the right to submit claims for medical expenses incurred after the date such Qualified Reservist Distribution is requested. The Plan shall pay the Qualified Reservist Distribution to the Participant within a reasonable time, but not more than sixty days after the request for a Qualified Reservist Distribution has been made.
(c) This Subsection shall be construed in accordance with IRS Notice 2008-82 and any superseding guidance.

Section 7.10 SEPARATE PLAN

Although described within this document, the HSA-Compatible Health FSA is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 105. The Health FSA is also a separate plan for purposes of ERISA, HIPAA, and COBRA, if applicable.

ARTICLE 8. DEPENDENT CARE ASSISTANCE PLAN ACCOUNT

Section 8.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Dependent Care Assistance Plan Accounts, an Eligible Employee may elect to have a portion of his or her Compensation contributed to a DCAP Account. The Account established under this Article 8 is intended to qualify as a dependent care assistance program under Code section 129 and shall be interpreted in a manner consistent with such Code section.

Section 8.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 are eligible to participate in the Dependent Care Assistance Plan Account, except as specified in the Adoption Agreement.

Section 8.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the DCAP Account in accordance with Article 4.
(b) *Contributions.* A Participant's DCAP Account will be credited with amounts withheld from the Participant's Compensation and any

amounts contributed by the Employer pursuant to the Adoption Agreement.

(c) *Failure to Elect.* Except as provided in the Adoption Agreement, an Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to a DCAP Account for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 8.04 LIMITS

The amount of all contributions to a Participant's DCAP Account shall not exceed the maximum annual limit described in the Adoption Agreement, and in no event shall exceed the limitations set forth in Code section 129(a)(2), as adjusted.

Section 8.05 ELIGIBLE EXPENSES

(a) *Debits from the DCAP Account.* A Participant's DCAP Account will be debited for expenses described in this Section 8.05. However, the Plan Administrator will not direct the Employer to reimburse such expenses to the extent the reimbursement exceeds the balance of the Participant's DCAP Account, except as otherwise provided in the Adoption Agreement.

(b) *Eligible Expenses.*

(1) Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her DCAP Account for Dependent Care Expenses that are: (i) incurred in the Plan Year, (ii) are incurred while the Participant participates in the Plan, and (iii) qualify as eligible Dependent Care Expenses (as defined in Section 8.05(b)(2) below), provided that such expenses that are not covered, paid or reimbursed from any other source and the Participant does not claim a tax benefit for the such expenses.

(2) "Dependent Care Expenses" are expenses incurred for the care of a Qualifying Individual, as defined in Code section 21(b)(1) and generally includes either: (i) a Dependent who is under age 13, or (ii) the Participant's spouse or Dependent who lives with the Participant and is physically or mentally incapable of caring for himself/herself. However, these expenses are Dependent Care Expenses only if they allow the Participant to be gainfully employed. Dependent Care Expenses include expenses for household services and expenses for the care of a Qualifying Individual. Such term shall not include any amount paid for services outside the Participant's household at a camp where the Qualifying Individual stays overnight. Expenses described in this subsection (2) that are incurred for services outside the Participant's household are not taken into account if they are incurred on behalf of the Participant's spouse or Dependent who is physically or mentally incapable of caring for himself/herself unless such individual lives at least eight hours per day in the Participant household. Expenses incurred at a dependent care center are taken into account only if such center complies with all applicable laws and regulations of a state or local government, the center provides care for more than six individuals, and the center receives a fee, payment, or grant for providing services for any of the individuals.

Section 8.06 REIMBURSEMENT

(a) *Period for Reimbursement.* The Plan Administrator shall direct the reimbursement from a Participant's DCAP Account for eligible expenses incurred during the Plan Year or as otherwise provided in the Adoption Agreement. If the Adoption Agreement so provides, the unused contributions that remain in a Participant's DCAP Account at the end of a Plan Year may be used to reimburse expenses that are incurred during a Grace Period beginning on the first day of the subsequent Plan Year and ending no later than the fifteenth day of the third calendar month of such Plan Year, in accordance with IRS Notice 2005-42, as amended or superseded. If the Adoption Agreement so provides, an individual who ceases to be a Participant in the Plan (due to Termination or any other reason) may spend down his or her unused DCAP Account expenses, and such individuals may be reimbursed for unused benefits through the end of the Plan Year in which the Termination of Participation occurs (or end of the Grace Period if applicable) to the extent the claims do not exceed the balance of the DCAP Account.

(b) *Period for Submitting Claims.* A Participant may submit a request for reimbursement from his or her DCAP Account during the Plan Year and no later than the date specified in the Adoption Agreement. The claim must be made in the manner required by the Plan Administrator.

(c) *Payment of Claims.* To the extent that the Plan Administrator approves the claim, the Employer shall: (i) reimburse the Participant, or (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from DCAP Account. The Plan Administrator may provide that payments/reimbursements from the DCAP Account of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year (or Grace Period, if applicable) shall be reimbursed without regard to the minimum payment amount.

(d) *Debit Card.* Subject to IRS guidelines, the Plan Administrator may provide for the use of debit or stored value cards for payment of eligible DCAP Account expenses.

Section 8.07 FORFEITURES

Any balance remaining in a Participant's DCAP Account at the end of any Plan Year (or after the Grace Period described in Section 8.06(a), if applicable) shall be forfeited and shall remain the property of the Employer. Unused contributions to a DCAP Account may not be cashed-out or converted to any other taxable or nontaxable benefit.

Section 8.08 TERMINATION OF EMPLOYMENT

Except as provided in the Adoption Agreement, contributions to a Participant's DCAP Account shall cease upon Termination of Employment. Any balance remaining in a Participant's DCAP Account on the date of his or her Termination of Employment shall be forfeited and shall remain the property of the Employer, except as expressly provided herein. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within 30 days following Termination of Employment, unless a different period for submitting claims following Termination of Employment is indicated in the Adoption Agreement.

Section 8.09 SEPARATE PLAN

Although described within this document, the DCAP Account is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 129. The DCAP Account is also a separate plan for purposes of ERISA, HIPAA, and COBRA, if applicable.

ARTICLE 9. HEALTH SAVINGS ACCOUNT

Section 9.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Health Savings Accounts, an Eligible Employee may elect to have a portion of his or her Compensation contributed to a Health Savings Account. The Account established under this Article 9 is intended to qualify as a health savings account under Code section 223 and shall be interpreted in a manner consistent with such Code section.

Section 9.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 who, as of the first day of the month, are enrolled in a high deductible health plan as defined in Code section 223(c)(2) are eligible to participate in the Health Savings Account for the month, except as specified in the Adoption Agreement. An Eligible Employee who has elected to participate in a General Purpose Health FSA is not eligible to participate in the HSA Benefit under this Article 9. A Participant who has elected the General Purpose Health FSA Benefit that is in effect on the last day of a Plan Year cannot elect the HSA Benefit under this Article 9 for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's General Purpose Health FSA is $0 as of the last day of such Plan Year. An Eligible Employee who is not enrolled in a high deductible health plan as defined in Code section 223(c)(2) is not eligible to elect the HSA Benefit.

Section 9.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the HSA in accordance with Article 4. An HSA election may be modified as determined by the Plan Administrator, but no less frequently than monthly, provided, however, that any modification of an election during the Plan Year shall apply on a prospective basis only. A participant who becomes ineligible to make HSA contributions may prospectively revoke his or her HSA contribution election.
(b) *Contributions.* A Participant's HSA will be credited with amounts withheld from the Participant's Compensation and any amounts contributed by the Employer pursuant to the Adoption Agreement.
(c) *Failure to Elect.* Except as provided in the Adoption Agreement, an Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to an HSA for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 9.04 LIMITS

The amount of contributions to a Participant's HSA shall not exceed the maximum annual limit described in the Adoption Agreement, and in no event

shall exceed the limitations set forth in Code section 223(b), as adjusted.

Section 9.05 ADMINISTRATION

The HSA Benefit is not an employer-sponsored employee benefit plan - it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the Employer does not establish or maintain the HSA. The Plan Administrator will maintain records to keep track of HSA contributions by the Employer and by the Participant, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

Section 9.06 TERMINATION OF EMPLOYMENT

Except as expressly provided herein, all contributions to a Participant's HSA will terminate upon a Termination of Employment. The Participant will continue to be eligible to receive a distribution from his or her HSA in accordance with the terms of the documents governing the HSA.

ARTICLE 10. ADOPTION ASSISTANCE FLEXIBLE SPENDING ACCOUNT

Section 10.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Adoption Assistance Flexible Spending Accounts, an Eligible Employee may elect to have a portion of his or her Compensation contributed to an Adoption Assistance FSA. The Account established under this Article 10 is intended to qualify as an adoption assistance program under Code section 137 and shall be interpreted in a manner consistent with such Code section.

Section 10.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 are eligible to participate in the Adoption Assistance FSA, except as specified in the Adoption Agreement.

Section 10.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the Adoption Assistance FSA in accordance with Article 4.
(b) *Contributions.* A Participant's Adoption Assistance FSA will be credited with amounts withheld from the Participant's Compensation and any amounts contributed by the Employer pursuant to the Adoption Agreement.
(c) *Failure to Elect.* Except as provided in the Adoption Agreement, an Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to an Adoption Assistance FSA for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 10.04 LIMITS

The amount of contributions to a Participant's Adoption Assistance FSA shall not exceed the maximum annual limit described in the Adoption Agreement, and in no event shall exceed the limitations set forth in Code section 137(b)(1).

Section 10.05 ELIGIBLE EXPENSES

(a) *Debits from the Adoption Assistance FSA.* A Participant's Adoption Assistance FSA will be debited for expenses described in this Section 10.05. However, the Plan Administrator will not direct the Employer to reimburse such expenses to the extent the reimbursement exceeds the balance of a Participant's Adoption Assistance FSA, except as otherwise provided in the Adoption Agreement.
(b) *Eligible Expenses.*
    (1) Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her Adoption Assistance FSA for expenses that: (i) are incurred in the Plan Year, (ii) are incurred while the Participant participates in the Plan, and (iii) qualify as eligible Adoption Expenses, (as defined in Section 10.05(b)(2) below) provided that such expenses are not covered, paid or reimbursed from any other source and the Participant does not claim a tax benefit for the such expenses.
    (2) "Adoption Expenses" are the reasonable and necessary adoption fees, court costs, attorney fees and other expenses that are (i) directly related to the legal adoption of an Eligible Child by the Participant and (ii) not incurred in violation of state or federal law or in carrying out any surrogate parenting arrangement. For purposes of this paragraph, an "Eligible Child" is a child under age 18

or a child who is physically or mentally incapable of caring for himself/herself. An Eligible Child does not include a child of the Participant's spouse. In the case of an adoption of a child who is not a citizen or resident of the United States, any Adoption Expense with respect to such adoption is not reimbursable until such adoption becomes final.

Section 10.06 REIMBURSEMENT

(a) *Period for Reimbursement.* The Plan Administrator shall direct the reimbursement from a Participant's Adoption Assistance FSA for eligible expenses incurred during the Plan Year or as otherwise provided in the Adoption Agreement. If the Adoption Agreement so provides, the unused contributions that remain in a Participant's Adoption Assistance FSA at the end of a Plan Year may be used to reimburse expenses that are incurred during a "Grace Period" beginning on the first day of the subsequent Plan Year and ending no later than the fifteenth day of the third calendar month of such Plan Year, in accordance with Prop. Treas. Reg. section 1.125-1(e), as amended or superseded.

(b) *Period for Submitting Claims.* A Participant may submit a request for reimbursement from his or her Adoption Assistance FSA during the Plan Year and no later than the date specified in the Adoption Agreement. The claim must be made in the manner required by the Plan Administrator.

(c) *Substantiation of Claims.* A Participant's claim for reimbursement from an Adoption Assistance FSA must include reasonable substantiation that the claim constitutes an Adoption Expense eligible for reimbursement under the Plan.

(d) *Payment of Claims.* To the extent that the Plan Administrator approves the claim, the Employer shall reimburse the Participant. The Plan Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. The Plan Administrator may provide that payments/reimbursements from the Adoption Assistance FSA of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year (or Grace Period, if applicable) shall be reimbursed without regard to the minimum payment amount.

Section 10.07 FORFEITURES

Any balance remaining in a Participant's Adoption Assistance FSA at the end of any Plan Year (or after the Grace Period described in Section 10.06(a), if applicable), shall be forfeited and shall remain the property of the Employer.

Section 10.08 TERMINATION OF EMPLOYMENT

Except as expressly provided herein, any balance remaining in a Participant's Adoption Assistance FSA on the date of his or her Termination of Employment shall be forfeited and shall remain the property of the Employer. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within 30 days following Termination of Employment, unless a different period for submitting claims following Termination of Employment is indicated in the Adoption Agreement.

Section 10.09 SEPARATE PLAN

Although described within this document, the Adoption Assistance FSA is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 137. The Adoption Assistance FSA is also a separate plan for purposes of ERISA, HIPAA, and COBRA, if applicable.

ARTICLE 11. OTHER BENEFITS

Section 11.01 FLEX CREDITS

(a) *In General.* To the extent the Adoption Agreement authorizes Flex Credits, an Employer may make a non-elective contribution to the Plan that may be used at each Participant's election for one or more Benefits under the Plan.

(b) *401(k) Contributions.* To the extent provided in the Adoption Agreement, an Eligible Employee may elect to contribute all or a portion of his or her Flex Credits to a Qualified Plan in accordance with the terms of the Qualified Plan, the applicable provisions of which are incorporated herein by reference. All claims for benefits that are provided under the Qualified Plan shall be governed by the terms of the Qualified Plan.

Section 11.02 PURCHASE/SALE OF PTO

(a) *In General.* To the extent that the Adoption Agreement authorizes the purchase and/or sale of PTO, an Eligible Employee may elect to purchase PTO days and/or sell PTO days.

(b) *Eligible Employees.* The Employees identified in Article 3 are eligible to purchase/sell PTO days, except as specified in the Adoption Agreement.

(c) *Enrollment.* An Eligible Employee may elect to purchase PTO days at such time as an Eligible Employee may enroll in the Plan in accordance with Article 4 and to the extent the Adoption Agreement provides. A Participant's PTO Account will be credited with amounts withheld from the Participant's Compensation in accordance with the Participant's Salary Reduction Agreement and any amounts contributed by the Employer pursuant to the Adoption Agreement. The Participant may use these amounts to purchase PTO days.

(d) *Failure to Elect.* An Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to a PTO Account for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

(e) *Forfeiture.* A Participant must use PTO during the Plan Year in which it was purchased. Any unused elective PTO (determined as of the last day of the Plan Year) shall either be paid in cash or be forfeited as of the end of the Plan Year, pursuant to the Adoption Agreement. The Participant must receive the cash on or before the last day of the Plan Year to which the amounts contributed and used to purchase the unused PTO relate.

(f) *Ordering of Elective and Non-elective PTO.* Participants are deemed to use PTO in the following order:
   (1) Non-elective PTO (that is, paid time off with respect to which the employee has no election to buy/sell) is used first; then
   (2) Elective PTO is used after all non-elective PTO is used.

(g) *Sale of PTO.* An Eligible Employee may elect to sell PTO days at such time as an Eligible Employee may enroll in the Plan in accordance with Article 4 and to the extent the Adoption Agreement provides. A Participant's PTO Account will be credited with the value of the PTO sold in accordance with the Eligible Employee's election. The Participant may use the amounts in the PTO Account to purchase other Benefits under the Plan or may cash out the amounts in the PTO Account in accordance with Section 11.03.

(h) *Carryover of Unused PTO.* To the extend provided in the Adoption Agreement, unused elective PTO (determined as of the last day of the Plan Year) may be carried over to a subsequent Plan Year at the Participant's election, subject to the Employer's PTO policies.

Section 11.03 CASH OUT

(a) *In General.* To the extent provided in the Adoption Agreement, a Participant may elect to receive a cash distribution of Flex Credits and PTO from the Plan.

(b) *Eligible Employees.* The Employees identified in Article 3 are eligible to receive a cash distribution from the Plan under this Section 11.03.

ARTICLE 12. SIMPLE CAFETERIA PLAN

Section 12.01 IN GENERAL

If the Adoption Agreement indicates this Plan is intended to be a simple cafeteria plan and the requirements of Code section 125(j) are met for any year, the nondiscrimination requirements of Code sections 125(b), 79(d), 105(h) and 129(d)(2), (3), (4), and (8) shall be treated as met during such year.

Section 12.02 ELIGIBLE EMPLOYERS

(a) The Plan shall not be a simple cafeteria plan if the Employer employed more than 100 Employees on business days during either of the two years preceding the date of the election. If the Employer was not in existence throughout the preceding year, the number of Employees shall be based on the average number of Employees that it is reasonably expect to employ on business days in the current year.

(b) If an Employer maintains the Plan as a simple cafeteria plan for its Employees then, if the Employer fails to meet the requirements of subparagraph (a) for any subsequent year, the Plan will continue to be a simple cafeteria plan for such subsequent year with respect to its Employees, unless and until the Employer employs an average of 200 or more Employees on business days during any year preceding any such subsequent year.

Section 12.03 EMPLOYER CONTRIBUTIONS

(a) *Required Employer Contributions.* The Employer shall make a contribution to provide Qualified Benefits under the Plan on behalf of each Eligible Employee who is not a Highly Compensated Employee or Key Employee (without regard to whether the Eligible Employee makes any salary reduction contribution) in an amount equal to:
  (1) a uniform percentage (not less than two percent) of the Employee's Compensation for the Plan Year, or
  (2) an amount which is not less than the lesser of:
    (A) six percent of the Employee's Compensation for the Plan Year, or
    (B) twice the amount of the salary reduction contributions of each Eligible Employee who is not a Highly Compensated Employee or Key Employee.

(b) *Additional Employer Contributions.* An Employer may elect to make additional contributions to the Plan, subject to the terms set forth herein; provided, however, that the rate of contributions with respect to any Participant contribution by a Highly Compensated Employee or Key Employee at any rate of contribution is not greater than the rate of contributions with respect to an employee who is not a Highly Compensated Employee or Key Employee.

Section 12.04 ELIGIBLE EMPLOYEES

To the extent that the Plan is intended to qualify as a simple cafeteria plan under Code section 125, all Employees who had at least 1,000 hours of service for the immediately preceding Plan Year are eligible to participate in the Plan, and each Employee eligible to participate in the Plan may, subject to terms and conditions applicable to all Participants, elect any Benefit available under the Plan.

ARTICLE 13. NONDISCRIMINATION

Section 13.01 NONDISCRIMINATION REQUIREMENTS

Unless the Adoption Agreement indicates this Plan is intended to be a simple cafeteria plan and the requirements of Code section 125(j) are met for any year, the following nondiscrimination requirements shall apply:

(a) *Cafeteria Plan.* The Plan may not discriminate in favor of Highly Compensated Individuals as to benefits provided or eligibility to participate.

(b) *Group Term Life.* The Plan may not discriminate in favor of Key Employees as to benefits provided or eligibility to participate with respect to any group term life insurance offered pursuant to Section 4.01.

(c) *Health Flexible Spending Account.* The Plan may not discriminate in favor of Highly Compensated Individuals as to benefits provided or eligibility to participate with respect to the Health FSA.

(d) *Dependent Care Assistance Plan Accounts.* The Plan may not discriminate in favor of Highly Compensated Employees as to benefits provided or eligibility to participate with respect to DCAP Accounts.

(e) *Adoption Assistance FSAs.* The Plan may not discriminate in favor of Highly Compensated Employees as to benefits provided or eligibility to participate with respect to Adoption Assistance FSAs.

Section 13.02 ADJUSTMENTS

If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify any election in order to assure compliance with such requirements or limitations. Any act taken by the Plan Administrator under this Section 13.02 shall be carried out in a uniform and non-discriminatory manner.

ARTICLE 14. PLAN ADMINISTRATION

Section 14.01 PLAN ADMINISTRATOR

(a) *Designation.* The Plan Administrator shall be specified in the Adoption Agreement. In the absence of a designation in the Adoption Agreement, the Plan Sponsor shall be the Plan Administrator. If a Committee is designated as the Plan Administrator, the Committee shall consist of one or more individuals who may be Employees appointed by the Plan Sponsor. The Committee shall elect a chair and may adopt such rules and procedures as it deems desirable. The Committee may also take action with or without formal meetings and may

authorize one or more individuals, who may or may not be members of the Committee, to execute documents on its behalf. The Plan Administrator shall also be the Plan "administrator" as such term is defined in section 3(16) of ERISA and the "named fiduciary" of the Plan (only to the extent that the Plan is subject to ERISA).

(b) *Authority and Responsibility of the Plan Administrator.* The Plan Administration shall have total and complete discretionary power and authority:

(1) to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation or application of the Plan by the Plan Administrator shall be final, conclusive and binding;

(2) to determine the amount, form or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for benefits under the Plan;

(3) to determine the amount and manner of any allocations hereunder;

(4) to maintain and preserve records relating to the Plan;

(5) to prepare and furnish all information and notices required under applicable law or the provisions of this Plan;

(6) to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all reports and other information required under law to be so filed or published;

(7) to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;

(8) to determine all questions of the eligibility and of the status of rights of Participants;

(9) to adjust Accounts in order to correct errors or omissions;

(10) to determine the validity of any judicial order;

(11) to retain records on elections and waivers by Participants;

(12) to supply such information to any person as may be required; and

(13) to perform such other functions and duties as are set forth in the Plan that are not specifically given to any other fiduciary or other person.

(c) *Procedures.* The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished to it. The Plan Administrator's decisions shall be binding and conclusive as to all parties.

(d) *Allocation of Duties and Responsibilities.* The Plan Administrator may designate other persons to carry out any of his duties and responsibilities under the Plan.

(e) *Compensation.* The Plan Administrator shall serve without compensation for its services.

(f) *Expenses.* All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder shall be paid or reimbursed by the Plan Sponsor.

Section 14.02 INDEMNIFICATION

Unless otherwise provided in the Adoption Agreement, the Plan Sponsor shall indemnify and hold harmless any person serving as the Plan Administrator (and its delegates) from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under this Plan or ERISA to the extent that the Plan is subject to ERISA.

ARTICLE 15. AMENDMENT AND TERMINATION

Section 15.01 AMENDMENT

The provisions of the Plan may be amended in writing at any time and from time to time by the Plan Sponsor or its delegate.

Section 15.02 TERMINATION

(a) It is the intention of the Plan Sponsor that this Plan will continue indefinitely; however, the Plan Sponsor reserves the right to terminate the Plan at any time for any reason.

(b) A participating Employer may terminate its participation in this Plan upon (i) written notice to the Plan Sponsor of its intent to terminate

participation in the Plan, (ii) the closing of a merger in which the participating Employer is not the surviving entity and the surviving entity is not an affiliate of the Plan Sponsor, or (iii) the sale of all or substantially all of the participating Employer's assets to an entity that is not an affiliate of the Plan Sponsor.

ARTICLE 16. CLAIMS PROCEDURES

Section 16.01 CONTRACT BENEFIT AND HSA CLAIMS

(a) *Benefits Provided by Contracts.* Claims and reimbursement for benefits provided under any Contract shall be administered in accordance with the claims procedures for the applicable Contract, as set forth in the Contract's plan documents, summary plan description, and/or similar documentation.

(b) *HSA Claims.* Claims relating to the HSA shall be administered by the HSA trustee/custodian in accordance with the HSA trust or custodial document between the Participant and such trustee/custodian.

Section 16.02 CLAIMS PROCEDURES FOR PLAN ACCOUNTS (OTHER THAN CONTRACT BENEFITS AND HSA)

(a) *Claims.* A request for benefits is a "claim" subject to this Section only if it is filed by the Participant or the Participant's authorized representative in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that the inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to process the claim, the Participant will be given an opportunity to provide the missing information. Participants may designate an authorized representative if written notice of such designation is provided.

(b) *Documentation.* A Participant or any other person requesting benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim shall include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim. All claims and notices shall be made in written form unless the Plan Administrator provides procedures for such claims and notices to be made in electronic and/or telephonic format to the extent that such alternative format is permitted under applicable law.

(c) *Health Flexible Spending Account Claims.* This Section 16.02(c) shall apply for any claim for benefits under the Health Flexible Spending Account.

(1) *Timing of Notice of Denied Claim.* The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(2) *Content of Notice of Denied Claim.* If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (A) the reason or reasons for such denial, (B) the pertinent Plan provisions on which the denial is based, (C) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (D) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA after following the Plan's claims procedures, and (E): (1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or (2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(3) *Appeal of Denied Claim.* If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 180th day after he receives the Plan Administrator's notice that the claim has been wholly or partially denied. The

Claimant shall lose the right to appeal if the appeal is not timely made. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator shall:

(A) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(B) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(C) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(D) Provide that the health care professional engaged for purposes of a consultation under Subsection (B) shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination.

(4) *Denial of Appeal.* If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (A) the reason or reasons for such denial, (B) the pertinent Plan provisions on which the denial is based, (C) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (D) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA after following the Plan's claims procedures. The determination rendered by the Plan Administrator shall be binding upon all parties.

(5) *Exhaustion of Remedies; Limitations Period for Filing Suit.* Before a suit can be filed in federal court, claims must exhaust internal remedies. Unless otherwise provided under the Plan or required pursuant to applicable law, a suit for benefits under the Health Flexible Spending Account must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

(d) *Other Plan Account Claims.* This Section 16.02(d) shall apply for any claim for benefits under Accounts other than the Health Flexible Spending Account.

(1) Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, ordinarily within 90 days after receipt of the claim, unless the Plan Administrator determines additional time is required to make a determination.

(2) *Content of Notice of Denied Claim.* If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a written notice identifying the reason or reasons for such denial and an explanation of the steps that the Claimant must take if he wishes to appeal the denial.

(3) *Appeal of Denied Claim.* If a Claimant wishes to appeal the denial of a claim, he shall file a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied. The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. A written appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Claimant shall lose the right to appeal if the appeal is not timely made. The Plan Administrator shall rule on an appeal within a reasonable period of time, ordinarily within 60 days of receipt of the appeal, unless the Plan Administrator determines additional time is required to make a determination.

(4) *Denial of Appeal.* If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying the reason or reasons for such denial. The determination rendered by the Plan Administrator shall be binding upon all parties.

(5) *Exhaustion of Remedies; Limitations Period for Filing Suit.* Unless otherwise prohibited under the Plan or pursuant to applicable law, before a suit can be filed in court, Claimants must exhaust the Plan's claim procedures. Unless otherwise provided under the Plan or required pursuant to applicable law, a suit for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

Section 16.03 REFUNDS/INDEMNIFICATION

If the Plan Administrator determines that any Claimant has directly or indirectly received excess payments/reimbursements or has received payments/reimbursements that are taxable to the Claimant, the Plan Administrator shall notify the Claimant and the Claimant shall repay such excess amount (or at the option of the Plan Administrator, the Claimant shall repay the amount that should have been withheld or paid as payroll or withholding taxes) as soon as possible, but in no event later than 30 days after the date of notification. A Claimant shall indemnify and reimburse the Employer for any liability the Employer may incur for making such payments, including but not limited to failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If the Claimant fails to timely repay an excess amount and/or make sufficient indemnification, the Plan Administrator may: (a) to the extent permitted by applicable law, offset the Claimant's salary or wages, and/or (b) offset other benefits payable hereunder.

ARTICLE 17. MISCELLANEOUS

Section 17.01 NONALIENATION OF BENEFITS

No Participant or Beneficiary shall have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which he or she may expect to receive, contingently or otherwise, under the Plan.

Section 17.02 NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan shall be construed as a contract of employment between the Employer and the Participant, or as a right of any Employee to continue in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its Employees, with or without cause.

Section 17.03 NO FUNDING REQUIRED

Except as otherwise required by law:

(a) Any amount contributed by a Participant and/or the Employer to provide benefits hereunder shall remain part of the general assets of the Employer and all payments of benefits under the Plan shall be made solely out of the general assets of the Employer.
(b) The Employer shall have no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. However, the Employer may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making any benefit payments under this Plan.
(c) No person shall have any rights to, or interest in, any Benefit or account other than as expressly authorized in the Plan.

Section 17.04 MEDICAL CHILD SUPPORT ORDERS

In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA section 609(a)(2)(B)), the Plan Administrator shall notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of ERISA section 609(a)(2)(A)). Within a reasonable period the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and alternate recipient of such determination.

To the extent the Plan is not subject to ERISA, any applicable law related to qualified medical child support orders or National Medical Support Notices shall apply and the Plan Administrator shall follow any required procedures under such law.

Section 17.05 GOVERNING LAW

(a) The Plan shall be construed in accordance with and governed by the laws of the state or commonwealth identified in the Adoption Agreement, to the extent not preempted by Federal law.
(b) The Plan hereby incorporates by reference any provisions required by state law to the extent not preempted by Federal law.

Section 17.06 TAX EFFECT

The Employer does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan.

Section 17.07 SEVERABILITY OF PROVISIONS

If any provision of the Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and the Plan shall be construed and enforced as if such provisions had not been included.

Section 17.08 HEADINGS AND CAPTIONS

The headings and captions herein are provided for reference and convenience only, shall not be considered part of the Plan, and shall not be employed in the construction of the Plan.

Section 17.09 GENDER AND NUMBER

Except where otherwise clearly indicated by context, the masculine and the neuter shall include the feminine and the neuter, the singular shall include the plural, and vice-versa.

Section 17.10 TRANSFERS

Except as explicitly set forth herein, amounts may not be transferred between Accounts.

Section 17.11 COBRA

If the Plan or Benefit is subject to COBRA (Code section 4980B and other applicable state law) or the Plan Administrator determines that the Plan or Benefit is subject to COBRA, a Participant shall be entitled to continuation coverage as prescribed in Code section 4980B (and the regulations thereunder) or such applicable state statutes.

Section 17.12 CONFLICTS

In the event of a conflict between the terms of this Plan and the terms of a Contract, the terms of the Contract (or the benefit plan under which it is established) shall control in defining the terms and conditions of coverage including, but not limited to, the persons eligible for coverage, the dates of their eligibility, the conditions that must be satisfied to become covered, if any, the benefits Participants are entitled to receive and the circumstances under which coverage terminates.

Section 17.13 DEATH

If a Participant dies, his beneficiaries or his estate may submit claims for expenses or benefits for the portion of the Plan Year preceding the date of the Participant's death. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Plan Administrator may pay any amount due hereunder to the Participant's spouse, one or more of his or her Dependents or a representative of the Participant's estate. Such payment shall fully discharge the Plan Administrator and the Employer from further liability on account thereof.

ARTICLE 18. HIPAA PRIVACY AND SECURITY COMPLIANCE

This Article 18 shall only apply in the event that the Health FSA(s) under the Plan constitutes a group health plan as defined in section 2791(a)(2) of the Public Health Service Act or if the Plan Administrator determines that the Plan is subject to the HIPAA privacy and security rules. The Plan will comply with HIPAA as set forth below.

Section 18.01 DEFINITIONS

For purposes of this Article 18, the following terms have the following meanings:

(a) Business Associate means

any outside vendor who performs a function or activity on behalf the Plan which involves the creation, use or disclosure of PHI, and includes any subcontractor to whom a Business Associate delegates its obligations.

(b) Group Health Benefits means

the medical benefits, dental benefits, vision benefits and, if applicable, employee assistance program benefits offered under the Plan.

(c) Individual means

the Participant or the Participant's covered dependents enrolled in any of the Group Health Benefits under the Plan.

(d) Notice of Privacy Practices means

a notice explaining the uses and disclosures of PHI that may be made by the Plan, the covered Individuals' rights under the Plan with respect to PHI, and the Plan's legal duties with respect to PHI.

(e) Plan Administration Functions means

the administration functions performed by the Plan Sponsor on behalf of the Plan. Plan Administration Functions do not include functions performed by the Plan Sponsor in connection with any other benefit plan of the Plan Sponsor.

(f) Protected Health Information ("PHI") means

information about an Individual, including genetic information, (whether oral or recorded in any form or medium) that:

(1) is created or received by the Plan or the Plan Sponsor;
(2) relates to the past, present or future physical or mental health or condition of the Individual, the provision of health care to the Individual, or the past, present or future payment for the provision of health care to the Individual; and
(3) identifies the Individual or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual.

PHI includes Protected Health Information that is transmitted by or maintained in electronic media.

(g) Summary Health Information means

information summarizing the claims history, claims expenses, or types of claims experienced by an Individual, and from which the following information has been removed:

(1) names;
(2) any geographic information which is more specific than a five digit zip code;
(3) all elements of dates relating to a covered Individual (*e.g.*, birth date) or any medical treatment (*e.g.*, admission date) except the year; all ages for a covered Individual if the Individual is over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);
(4) other identifying numbers, such as, Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;
(5) facial photographs or biometric identifiers (*e.g.*, finger prints); and
(6) any other unique identifying number, characteristic, or code.

Section 18.02 HIPAA PRIVACY COMPLIANCE The Plan's HIPAA privacy compliance rules ("Privacy Rule") are as follows:

(a) Permitted Use or Disclosure of PHI by Plan Sponsor. Any disclosure to and use by the Plan Sponsor of any PHI will be subject to and consistent with this Section.
   (1) The Plan and health insurance issuer, HMO, or Business Associate servicing the Plan may disclose PHI to the Plan Sponsor to permit the Plan Sponsor to carry out Plan Administration Functions, including but not limited to the following purposes:
      (A) to provide and conduct Plan Administrative Functions related to payment and health care operations for and on behalf of the Plan;
      (B) for auditing claims payments made by the Plan;
      (C) to request proposals for services to be provided to or on behalf of the Plan; and
      (D) to investigate fraud or other unlawful acts related to the Plan and committed or reasonably suspected of having been committed by a Plan participant.
   (2) The uses described above in (1) are permissible only if the Notice of Privacy Practices distributed to covered Individuals in accordance with the Privacy Rule states that PHI may be disclosed to the Plan Sponsor.
   (3) The Plan or a health insurance issuer or HMO may disclose to the Plan Sponsor information regarding whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.
(b) Restrictions on Plan Sponsor's Use and Disclosure of PHI.
   (1) The Plan Sponsor will not use or further disclose PHI, except as permitted or required by the Plan or as required by law.
   (2) The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides PHI agrees to the restrictions and conditions of this Section.
   (3) The Plan Sponsor will not, and will not permit a health insurance issuer or HMO to, use or disclose PHI for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(4) The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures allowed under this Section promptly upon learning of such inconsistent use or disclosure.
(5) The Plan Sponsor will make a covered Individual's PHI available to the covered Individual in accordance with the Privacy Rule.
(6) The Plan Sponsor will make PHI available for amendment and will, upon notice, amend PHI in accordance with the Privacy Rule.
(7) The Plan Sponsor will track certain PHI disclosures it makes so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with the Privacy Rule.
(8) The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with the Privacy Rule.
(9) The Plan Sponsor will, if feasible, return or destroy all PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control) received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Individual who is the subject of the PHI, when that PHI is no longer needed for the Plan Administration Functions for which the disclosure was made. If it is not feasible to return or destroy all such PHI, the Plan Sponsor will limit the use or disclosure of any PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.
(10) When using or disclosing PHI or when requesting PHI from another party, the Plan sponsor must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure, and limit any request for PHI to the minimum necessary to satisfy the purpose of the request.
(11) The Plan Sponsor will not use any genetic information for any underwriting purposes.

(c) Adequate Separation between the Plan Sponsor and the Plan.
(1) Only those employees of the Plan Sponsor, as outlined in the Plan's HIPAA Policies and Procedures, may be given access to PHI received from the Plan or a health insurance issuer, HMO or Business Associate servicing the Plan.
(2) The members of the classes of employees identified in the Plan's HIPAA Policies and Procedures will have access to PHI only to perform the Plan Administration Functions that the Plan Sponsor provides for the Plan.
(3) The Plan Sponsor will promptly report to the Plan any use or disclosure of PHI in breach, violation of, or noncompliance with, the provisions of this Section of the Plan, as required under this Section, and will cooperate with the Plan to correct the breach, violation or noncompliance, will impose appropriate disciplinary action or sanctions, including termination of employment, on each employee who is responsible for the breach, violation or noncompliance, and will mitigate any deleterious effect of the breach, violation or noncompliance on any Individual covered under the Plan, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance. Regardless of whether a person is disciplined or terminated pursuant to this section, the Plan reserves the right to direct that the Plan Sponsor, and upon receipt of such direction the Plan Sponsor shall, modify or revoke any person's access to or use of PHI.

(d) Purpose of Disclosure of Summary Health Information to Plan Sponsor.
(1) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan.
(2) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

(e) Plan Sponsor Certification. The Plan Sponsor will provide the Plan with a certification stating that the Plan has been amended to incorporate the terms of this Article and that the Plan Sponsor agrees to abide by these terms. The Plan Sponsor will also provide the certification upon request to its health insurance issuers, HMOs and Business Associates of the Plan.

Section 18.03 HIPAA SECURITY COMPLIANCE

To ensure the Plan's compliance with HIPAA's privacy compliance rules ("Security Rule"), the Plan Sponsor will:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
(b) Ensure that the adequate separation required by the HIPAA Security Rule is supported by reasonable and appropriate security measures;
(c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
(d) Report to the Plan any security incident of which it becomes aware.

Middle Bucks Institute of Technology
Joint Purchasing & Cooperatives
May 2021

- Member Districts
- BCIU – Cooperative Purchasing Group
- Lancaster – Lebanon IU
- Central Susquehanna IU
- Lincoln IU
- Pennsylvania Education Joint Purchasing Council
- Keystone Purchasing Network
- PEPPM
- U.S. Communities
- Omnia / US Communities /Amazon
- Equalis Group
- PA State Contracts
- COSTARS – Pennsylvania Department of General Services
- PA State Agency for Surplus Property
- PA Federal Surplus Property Program
- Western States Contracting Alliance
- U.S. General Services Administration
- Federal Schedule 70
- Buy Board
- National Joint Powers Alliance
- National IPA

Middle Bucks Institute of Technology

Li L Bucks Preschool at MBIT For the Period 04/01/2021 through 04/30/2021

Fiscal Year: 2020-2021

	04/01/2021 - 04/30/2021	Year To Date
INCOME		
TUITION & FEES		
PRE SCHOOL TUITION (+)	$23,308.54	$176,989.22
FEES & DEPOSITS (+)	$0.00	$1,400.00
Sub-total : TUITION & FEES	$23,308.54	$178,389.22
Total : INCOME	$23,308.54	$178,389.22
EXPENSES		
OPERATING EXPENSES		
WAGES (-)	$12,940.61	$110,535.51
BENEFITS (-)	$6,882.72	$60,424.63
PROF SERVICES (-)	$128.80	($113.05)
PROPERTY SERVICES (-)	$0.00	$1,950.00
OTHER PURCHASED SERVICES (-)	$0.00	$675.00
SUPPLIES (-)	$379.78	$24,736.67
EQUIPMENT (-)	$73.13	$475.33
DUES & FEES (-)	$413.97	$2,778.98
Sub-total : OPERATING EXPENSES	($20,819.01)	($201,463.07)
Total : EXPENSES	($20,819.01)	($201,463.07)
OTHER		
OTHER INCOME		
GRANTS (+)	$0.00	$3,000.00
CARES GRANT (+)	$0.00	$39,200.00
SUBSIDIES - SS & RETIREMENT (+)	$2,682.98	$22,453.29
Sub-total : OTHER INCOME	$2,682.98	$64,653.29
Total : OTHER	$2,682.98	$64,653.29
NET ADDITION/(DEFICIT)	$5,172.51	$41,579.44

End of Report

Middle Bucks Institute of Technology

Li L Bucks Preschool at MBIT As of 04/30/2021

Fiscal Year: 2020-2021

ASSETS		
CURRENT ASSETS		
CASH (+)	$63,801.48	
ACCOUNTS RECEIVABLE (+)	$260.13	
Sub-total : CURRENT ASSETS	$64,061.61	
CAPITAL ASSETS, NET ACCUM DEPREC		
EQUIPMENT (+)	$10,933.07	
Sub-total : CAPITAL ASSETS, NET ACCUM DEPREC	$10,933.07	
Total : ASSETS		$74,994.68
LIABILITIES		
EMPLOYMENT TAX WITHHOLDINGS		
PAYROLL WITHHOLDINGS (+)	$16,418.87	
Sub-total : EMPLOYMENT TAX WITHHOLDINGS	$16,418.87	
DEFERRED REVENUE		
DEPOSITS (+)	$1,200.00	
Sub-total : DEFERRED REVENUE	$1,200.00	
Total : LIABILITIES	$17,618.87	
EQUITY		
FUND BALANCE		
NET ASSETS (+)	$15,796.37	
Sub-total : FUND BALANCE	$15,796.37	
NET ADDITION/(DEFICIT)		
NET ADDITION/(DEFICIT) (+)	$41,579.44	
Sub-total : NET ADDITION/(DEFICIT)	$41,579.44	
Total : EQUITY	$57,375.81	
Total LIABILITIES + EQUITY		$74,994.68

End of Report

Middle Bucks Institute of Technology

Li L Bucks Preschool at MBIT For the Period 04/01/2020 through 04/30/2020

Fiscal Year: 2019-2020

	04/01/2020 - 04/30/2020	Year To Date
INCOME		
TUITION & FEES		
PRE SCHOOL TUITION (+)	$718.68	$142,139.52
Sub-total : TUITION & FEES	$718.68	$142,139.52
Total : INCOME	$718.68	$142,139.52
EXPENSES		
OPERATING EXPENSES		
WAGES (-)	$10,868.81	$97,951.73
BENEFITS (-)	$5,973.82	$54,330.51
PROF SERVICES (-)	$99.71	$520.66
OTHER PURCHASED SERVICES (-)	$92.25	$760.50
SUPPLIES (-)	$0.00	$9,283.49
EQUIPMENT (-)	$109.69	$1,096.91
DUES & FEES (-)	$437.21	$3,187.48
Sub-total : OPERATING EXPENSES	($17,581.49)	($167,131.28)
Total : EXPENSES	($17,581.49)	($167,131.28)
OTHER		
OTHER INCOME		
GRANTS (+)	$0.00	$7,915.00
OTHER (+)	$0.00	$545.71
SUBSIDIES - SS & RETIREMENT (+)	$2,000.73	$17,281.12
Sub-total : OTHER INCOME	$2,000.73	$25,741.83
Total : OTHER	$2,000.73	$25,741.83
NET ADDITION/(DEFICIT)	($14,862.08)	$750.07

End of Report

Middle Bucks Institute of Technology

Li L Bucks Preschool at MBIT As of 04/30/2020

Fiscal Year: 2019-2020

ASSETS		
CURRENT ASSETS		
CASH (+)	$61,895.93	
DUE FROM (TO) OTHER FUND (+)	($23.91)	
ACCOUNTS RECEIVABLE (+)	$249.03	
Sub-total : CURRENT ASSETS	$62,121.05	
CAPITAL ASSETS, NET ACCUM DEPREC		
EQUIPMENT (+)	$10,749.78	
Sub-total : CAPITAL ASSETS, NET ACCUM DEPREC	$10,749.78	
Total : ASSETS		$72,870.83
LIABILITIES		
EMPLOYMENT TAX WITHHOLDINGS		
PAYROLL WITHHOLDINGS (+)	$14,363.76	
Sub-total : EMPLOYMENT TAX WITHHOLDINGS	$14,363.76	
DEFERRED REVENUE		
DEPOSITS (+)	$14,487.07	
Sub-total : DEFERRED REVENUE	$14,487.07	
Total : LIABILITIES	$28,850.83	
EQUITY		
FUND BALANCE		
NET ASSETS (+)	$43,269.93	
Sub-total : FUND BALANCE	$43,269.93	
NET ADDITION/(DEFICIT)		
NET ADDITION/(DEFICIT) (+)	$750.07	
Sub-total : NET ADDITION/(DEFICIT)	$750.07	
Total : EQUITY	$44,020.00	
Total LIABILITIES + EQUITY		$72,870.83

End of Report

Middle Bucks Institute of Technology

Adult Education For the Period 04/01/2021 through 04/30/2021

Fiscal Year: 2020-2021

	04/01/2021 - 04/30/2021	Year To Date
INCOME		
Local Revenue		
Registration Fees & Tuition (+)	$400.00	$46,486.00
Sub-total : Local Revenue	$400.00	$46,486.00
State Subsidies		
Vocational Ed Subsidy - Adults (+)	$0.00	$5,168.26
Social Security Subsidy (+)	$142.36	$1,307.50
Retirement Subsidy (+)	$358.90	$5,104.48
Sub-total : State Subsidies	$501.26	$11,580.24
Total : INCOME	$901.26	$58,066.24
EXPENSES		
Salaries		
Administrative (-)	$0.00	$21,182.40
Instructors (-)	$3,240.00	$12,155.00
Support (-)	$519.99	$913.70
Sub-total : Salaries	($3,759.99)	($34,251.10)
Benefits		
Statutory (-)	$1,002.52	$13,932.06
Sub-total : Benefits	($1,002.52)	($13,932.06)
Property Services		
Repairs & Maintenance (-)	$4.95	$49.50
Sub-total : Property Services	($4.95)	($49.50)
Supplies		
Consumable Supplies (-)	$907.31	$4,479.61
Books & Periodicals (-)	$0.00	$2,707.73
Sub-total : Supplies	($907.31)	($7,187.34)
Other		
Dues & Fees (-)	$108.91	$2,545.20
Sub-total : Other	($108.91)	($2,545.20)
Total : EXPENSES	($5,783.68)	($57,965.20)
NET ADDITION/(DEFICIT)	($4,882.42)	$101.04

End of Report

Middle Bucks Institute of Technology

Adult Education As of 04/30/2021

Fiscal Year: 2020-2021

ASSETS		
CURRENT ASSETS		
CASH & INVESTMENTS (+)	$217,691.37	
Sub-total : CURRENT ASSETS	$217,691.37	
Total : ASSETS		$217,691.37
LIABILITIES		
CURRENT LIABILITIES		
ACCRUED BENEFITS (+)	$2,848.65	
Sub-total : CURRENT LIABILITIES	$2,848.65	
Total : LIABILITIES	$2,848.65	
EQUITY		
FUND BALANCE		
BEGINNING FUND BALANCE (+)	$214,741.68	
Sub-total : FUND BALANCE	$214,741.68	
NET ADDITION/(DEFICIT)		
NET ADDITION/(DEFICIT) (+)	$101.04	
Sub-total : NET ADDITION/(DEFICIT)	$101.04	
Total : EQUITY	$214,842.72	
Total LIABILITIES + EQUITY		$217,691.37

End of Report

Middle Bucks Institute of Technology

Adult Education For the Period 04/01/2020 through 04/30/2020

Fiscal Year: 2019-2020

	04/01/2020 - 04/30/2020	Year To Date
INCOME		
Local Revenue		
Registration Fees & Tuition (+)	$1,908.50	$97,321.49
Sub-total : Local Revenue	$1,908.50	$97,321.49
State Subsidies		
Vocational Ed Subsidy - Adults (+)	$0.00	$8,107.39
Social Security Subsidy (+)	$287.40	$2,279.79
Retirement Subsidy (+)	$701.69	$6,091.55
Sub-total : State Subsidies	$989.09	$16,478.73
Total : INCOME	$2,897.59	$113,800.22
EXPENSES		
Salaries		
Administrative (-)	$2,312.80	$25,440.80
Instructors (-)	$4,425.00	$28,680.00
Support (-)	$840.00	$5,914.79
Sub-total : Salaries	($7,577.80)	($60,035.59)
Benefits		
Statutory (-)	$1,978.20	$17,441.30
Sub-total : Benefits	($1,978.20)	($17,441.30)
Property Services		
Repairs & Maintenance (-)	$4.95	$49.50
Sub-total : Property Services	($4.95)	($49.50)
Other Purchased Services		
Postage (-)	$0.00	$9,629.97
Advertising (-)	$0.00	$967.75
Printing & Binding (-)	$0.00	$10,451.40
Travel & Prof. Development (-)	$0.00	$463.84
Sub-total : Other Purchased Services	$0.00	($21,512.96)
Supplies		
Consumable Supplies (-)	$0.00	$7,042.96
Books & Periodicals (-)	$0.00	$7,612.71
Software & Audio Visual (-)	$0.00	$90.66
Utilities (-)	$0.00	$2,174.91
Sub-total : Supplies	$0.00	($16,921.24)
Dues & Fees		
Dues & Fees (-)	($279.49)	$3,363.96
Sub-total : Dues & Fees	$279.49	($3,363.96)
Total : EXPENSES	($9,281.46)	($119,324.55)

Middle Bucks Institute of Technology

Adult Education For the Period 04/01/2020 through 04/30/2020

Fiscal Year: 2019-2020

	04/01/2020 - 04/30/2020	Year To Date
NET ADDITION/(DEFICIT)	($6,383.87)	($5,524.33)

End of Report

Middle Bucks Institute of Technology

Adult Education As of 04/30/2020

Fiscal Year: 2019-2020

ASSETS		
CURRENT ASSETS		
CASH & INVESTMENTS (+)	$226,209.16	
ACCOUNTS RECEIVABLE (+)	$44.00	
Sub-total : CURRENT ASSETS	$226,253.16	
Total : ASSETS		$226,253.16
LIABILITIES		
CURRENT LIABILITIES		
ACCRUED BENEFITS (+)	$5,546.25	
OTHER ACCRUED BENEFITS PAYABLE (+)	$8.18	
Sub-total : CURRENT LIABILITIES	$5,554.43	
Total : LIABILITIES	$5,554.43	
EQUITY		
FUND BALANCE		
BEGINNING FUND BALANCE (+)	$226,223.06	
Sub-total : FUND BALANCE	$226,223.06	
NET ADDITION/(DEFICIT)		
NET ADDITION/(DEFICIT) (+)	($5,524.33)	
Sub-total : NET ADDITION/(DEFICIT)	($5,524.33)	
Total : EQUITY	$220,698.73	
Total LIABILITIES + EQUITY		$226,253.16

End of Report